

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 1 0 5

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST HARRIET		MIDDLE LILLIAN		LAST HAILE		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH 12		DAY 4		YEAR 19 84		2b. HOUR M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH FEB. 6, 1958		DAY 26		6. AGE (IN YEARS) LAST BIRTHDAY 26 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		7c. DATE PRONOUNCED DEAD		MONTH 12		DAY 4		YEAR 19 84		2d. HOUR 1:51 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD													
10. CITY OR TOWN OF DEATH TOWSON				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1501 Providence Rd.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDITOR						12b. KIND OF BUSINESS OR INDUSTRY USF &G									
13a. STATE MARYLAND				13b. COUNTY BALTIMORE				13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3734 OLD YORK ROAD 21218									
14. FATHER'S NAME FIRST EDMUND				MIDDLE F.				LAST HAILE				15. MOTHER'S MAIDEN NAME FIRST SUSANNE				MIDDLE CROSBY				LAST CROSBY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES) -----				16b. SOCIAL SECURITY NO. 214-76-4297				17. INFORMANT EDMUND F. HAILE				ADDRESS 21204 1501 PROVIDENCE RD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
																		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-4- 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self.																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house				21f. LOCATION STREET 1501 Providence Rd.				CITY OR TOWN Balto.				COUNTY Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 12-5-84											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE DEC. 6, '84				23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY				23d. LOCATION CITY OR TOWN BALTIMORE, MARYLAND													
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR DEC 5 1984				25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>													



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 0 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Goba h. HALL			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1984			2b. HOUR P. 1:20 M.			
3 SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 10, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH Jowson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John A. Lawson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY C. Wilson			13e. STREET ADDRESS / ZIP CODE 3605 MONTREY ROAD 21218			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 28 2047		17. INFORMANT ADDRESS Family Records				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Metastatic Breast cancer Polycythemia Rubra Vera

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (we) attended the deceased from 1/83 19 84 to 12/28 19 84, that (we) last saw the deceased alive on 12/28 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John W. Bowie MD				DEGREE		22c. DATE SIGNED 12/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN W. BOWIE				22e. ADDRESS 500 West University P.K.W.Y.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE DEC. 31, 1984		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIALS 8800 HARFORD ROAD				25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified and a medicolegal certificate must be completed.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 0 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT S. HANSEN										2a. DATE OF DEATH MONTH DAY YEAR DEC. 1, 1984		2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/16/03		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD							
10. CITY OR TOWN OF DEATH MIDDLE RIVER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1234 BURKE RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO		12b. KIND OF BUSINESS OR INDUSTRY AUTO					
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN MIDDLE RIVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1234 BURKE RD. 21220					
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 03 2551		17. INFORMANT ADDRESS MARGARET HANSEN ABOVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNGS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WITH METASTASIS TO THE DUE TO, OR AS A CONSEQUENCE OF (c) BRAIN AND CHEST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from NOV. 10, 1984 to DEC 1, 1984 , that (I) (we) last saw the deceased alive on NOV. 10, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE OF DEGREE FAUSTO Q. AQUINO JR MD										22c. DATE SIGNED 12-4-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FAUSTO Q. AQUINO JR										22e. ADDRESS 8713 HARPER D RD. 21234			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/4/84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD							
24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MALE										25a. DATE REC'D. BY REGISTRAR DEC 4 1984		25b. REGISTRAR'S NAME J. G. CONNELLY	

MEDICAL CERTIFICATION

WATERMAN

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 1 0 8 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				7b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy B. Harned				December 7, 1984				10 ¹⁵ A.M.	
3 SEX F		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 14 1919		6 AGE (IN YEARS LAST BIRTHDAY) 65		7c. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co., MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7000 Stoneleigh Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Stoneleigh		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7000 Stoneleigh Ct. 21212	
14. FATHER'S NAME FIRST MIDDLE LAST George Clarence Bussing				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Feldman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 261-14-9609 A		17 INFORMANT ADDRESS Edward J. Harned 7000 Stoneleigh Ct. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of lung - metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>COPD</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>6-11</u> , 19 <u>70</u> , to <u>12-7</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12-4</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Walter G. Ossman Jr. MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred G. Ossman Jr. MD				22e. ADDRESS 1101 St Paul St Baltimore Md 21202					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/7/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE <u>ne Davidson-Randall</u>	

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					3 2 1 0 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MELVIN DOUGLAS HARRIS					2a. DATE OF DEATH MONTH DAY YEAR December 25, 1984				2b. HOUR 10:30 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 18, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Joppa, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH White Marsh		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11554 Pulaski Highway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN White Marsh		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11554 Pulaski Highway 21162		
14. FATHER'S NAME FIRST MIDDLE LAST Albert -- Harris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline (nmn) Davis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --				16b. SOCIAL SECURITY NO. 215-22-1648		17. INFORMANT ADDRESS White Marsh, Md. 21162 Mrs. Beatrice Harris, 11554 Pulaski Hwy.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) ~20 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~5 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) —						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from Dec 17 , 19 82 , to Dec , 19 84 that (1) (we) lost saw the deceased alive on Dec 17 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) not view the body after death.										
22b. SIGNATURE Richard A. Lange DEGREE MD						22c. DATE SIGNED Dec. 26, 1984				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Lange, M.D.						22e. ADDRESS 3804 Ednor Road, Baltimore, Md. 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1984		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens, Baltimore		23d. LOCATION CITY OR TOWN COUNTY STATE -- Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Richard Davidson-Randall		

BP

CHIEF

COPIES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 1 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) <i>Otto Hartman</i>		MONTH DAY YEAR <i>12-31-84</i>		A. <i>6:55</i> M.	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10-2-1901</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Balto. Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Dundalk</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian Heritage Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Accountant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>City of Balto.</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Md.</i>	13b. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>4931 Sxhaub Ave.-21206</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>George J. Hartman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma P. Hartman</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. <i>214-14-3189</i>	17. INFORMANT ADDRESS <i>Florence K. Hartman 4931 Schaub Ave. Balto. Md.-21206</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ca Bladder with mets</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/5</i> , 19 <i>84</i> , to <i>12/5</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12/5</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A. Mathys</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12-1-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>		25a. DATE RECEIVED BY REGISTRAR <i>JAN 2 1985</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 1 1

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
FIRST MIDDLE LAST		Dec. 22-84		12 Noon	
LOUISE LOUISE MARY MARY HARTSOCK					
3. SEX		4. RACE		5. DATE OF BIRTH	
F Female		W White		MONTH DAY YEAR	
				12-5-09	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto. CO TOWSON		Stella Maris		County Baltimore County	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Homemaker		Homemaker			
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Fla		St. Petersburg		4885 1st ST N.E. 33703	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Charles F. Bueke		Nellie - Braney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220108982		Stella Maris Hospice	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE Cause (a) ASCVD					
DUE TO, OR AS A CONSEQUENCE OF, (b) Alzheimers Type Dementia					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-6-84 to Dec. 22 1984, that (I) (we) last saw the deceased alive on 12-17-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Kendal Faulkner MD				12-22-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Kendal Faulkner MD		2300 Duhvey Valley Rd. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12-26-84		Memorial Park Cemetery	
				St. Petersburg, Florida	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Ruck Towson Funeral Home, Inc.		1050 York Rd. 21204		DEC 24 1984 Jane Davidson-Kendall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 1 2 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FLORENCE M. HEBERT				2a. DATE OF DEATH MONTH DAY YEAR 12 3 84			2b. HOUR 6 15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) East Point Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1170 Pelham Wood Rd. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST Luke Fountain				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Barette							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 091-28-6587		17. INFORMANT ADDRESS Armand L. Hebert - Same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary tract infection w/ sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10-23 , 19 84 , to 12-3 , 19 84 , that (I) (we) last saw the deceased alive on 12-3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J B LITTLETON						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J B LITTLETON						22e. ADDRESS 1012 Old Northbrook Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-6-84		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland				
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.						ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

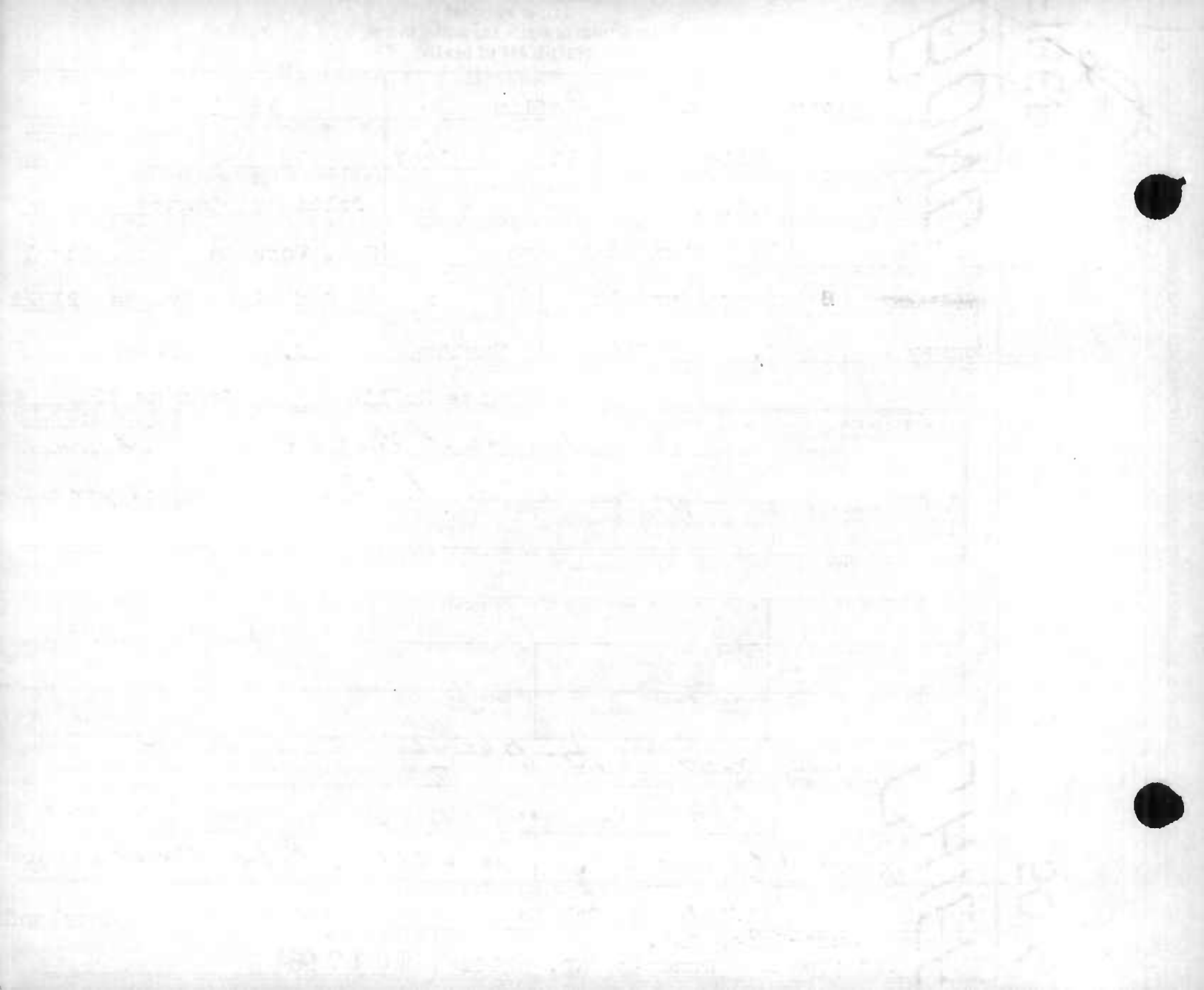
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 1 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Alger		MIDDLE R.		LAST Heflin		2a. DATE OF DEATH MONTH 12		YEAR 12		7b. HOUR 1984		M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 12		DAY 24		YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76		YRS		7c. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD									
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10 Seabright Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Foreman				12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10 Seabright Avenue 21222							
14. FATHER'S NAME FIRST Conway						MIDDLE C.						LAST Heflin			
15. MOTHER'S MAIDEN NAME FIRST Martha						MIDDLE F.						LAST Hicks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT Louise Heflin				Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Hypertensive Art. scl. CV Dis.</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>15 yrs.</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> , 19 <u>60</u> , to <u>12-12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>R. G. Windsor</u>								DEGREE <u>MD</u>				22c. DATE SIGNED <u>12-13-84</u>			
22d. PHYSICIAN'S NAME (TYPE COMPLETE) <u>R. G. Windsor</u>								22e. ADDRESS <u>1012 Old No. P. Rd. Balt 21224</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/15/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn				23d. LOCATION CITY OR TOWN Baltimore				COUNTY Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222								25a. DATE REC'D. BY REGISTRAR DEC 17 1984				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 1 1 4
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George Heinz			2a. DATE KNOWN OF DEATH ESTIMATED XX 12-26 1984			2b. HOUR a.m. 9:58		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb 11, 1952	6. AGE (IN YEARS) (LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD 12-29 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD		
10. CITY OR TOWN OF DEATH Kingsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12220 Belair Road 21087				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS 1426 Galena Rd. 21221		
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Heinz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tatjana Rhine			16. ADDRESS Baltimore, Md. 21220		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam		17. INFORMANT Ronald Ireland 12539 Gracewood Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? (Head Only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-26 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) motel room		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12220 Belair Road, Balto. Co., Maryland			
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquest <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant			DATE SIGNED 12-30-84		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan 3, 85		23c. NAME OF CEMETERY OR CREMATORY St. Andrews Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Doppel Funeral Homes, Inc.			7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR Jan 2 1985			

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1990; 16: 244-251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 1 1 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Bertie Mae Henderson			2a. DATE OF DEATH December 19 1984		2b. HOUR 9 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH Oct 18 1894	6. AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley View Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At Home
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME George W. Pettit			15. MOTHER'S MAIDEN NAME Alice Garrett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-02-4116		17. INFORMANT ADDRESS Shirley Henderson Same as item # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Anemia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) generalized osteoporosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6 19 84 , to 12/19/ 19 84 , that (I) (we) last saw the deceased alive on 12/19/ 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Vuong Vu Nguyen		DEGREE		22c. DATE SIGNED 12/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VUONG VU NGUYEN		22e. ADDRESS 6331 Belair Rd Balto Md 21206		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (S) Burial		23b. DATE 12/22/84		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill	
23d. LOCATION (CITY OR TOWN) Alexandria, Virginia		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Gina Davidson-Rodell	
24. FUNERAL DIRECTOR NAME Cunningham Funeral Home, Inc. ADDRESS Alex., Va.					

BP

20% COTTON

CHIEF



1/2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

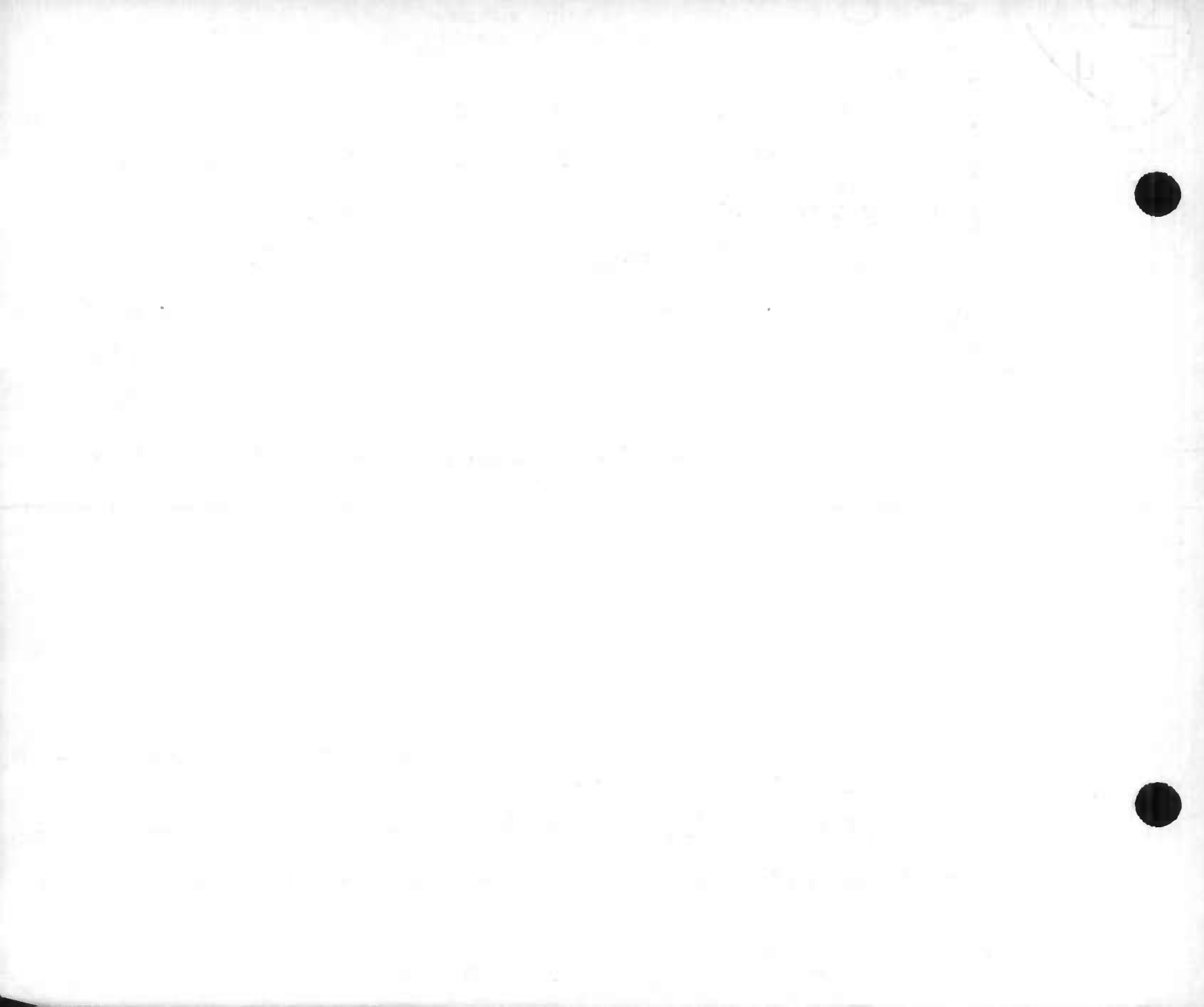
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 1 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUBY VIOLA HENDRICKS			2a. DATE OF DEATH MONTH DAY YEAR 12-9-84		2b. HOUR 3 P.M.						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 27 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.,		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County MD.					
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center-Heritage				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY Balto.		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7018 Mornington Rd. 21222		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Lupton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Not Known							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-3107		17. INFORMANT John Bowman				ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V.D. & chronic failure and</u> DUE TO, OR AS A CONSEQUENCE OF <u>atrial fibrillation.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Year.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 5</u> 19 <u>74</u> to <u>Dec 9</u> 19 <u>84</u> , that (I) (was) lost saw the deceased alive on <u>Dec 4</u> 19 <u>84</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (would) (did not) view the body after death.											
22b. SIGNATURE <u>Atallah Golpira</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-10-1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ATAOLLAH GOLPIRA, M.D.				22e. ADDRESS 3029 Dundalk ave. Balto. Md 21222							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/1984		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Md. 21222				25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE <u>Wardson Randall</u>					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mercedes Geraldine Henry						2a. DATE OF DEATH MONTH DAY YEAR 12 7 84			2b. HOUR 6:15P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 30 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 72 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2505 Eugene Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bert A. Ruth						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia H. Dougherty					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-80-4980		17. INFORMANT Suzane M. Bailey		ADDRESS 2505 Eugene Ave. Balto., MD. 21219					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma tons</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Breast R</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Art. Sclerotic Cardiovascular Disease.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>82</u> , to <u>Dec 7</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Dec 6</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Roger G. Windsor MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Roger G. Windsor		22e. ADDRESS 10120th No Point Rd Balt Md 21224									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/84		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home Inc.		ADDRESS 7922 Wise Ave.		25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE <u>R. Windsor</u>					

BP

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1917

No.		Name		Description		Quantity		Value	
1		Cotton		Cotton		100		100	
2		Wool		Wool		100		100	
3		Hides		Hides		100		100	
4		Fur		Fur		100		100	
5		Bones		Bones		100		100	
6		Tallow		Tallow		100		100	
7		Horn		Horn		100		100	
8		Hoof		Hoof		100		100	
9		Manure		Manure		100		100	
10		Blood		Blood		100		100	
11		Hair		Hair		100		100	
12		Skins		Skins		100		100	
13		Leather		Leather		100		100	
14		Fur		Fur		100		100	
15		Bones		Bones		100		100	
16		Tallow		Tallow		100		100	
17		Horn		Horn		100		100	
18		Hoof		Hoof		100		100	
19		Manure		Manure		100		100	
20		Blood		Blood		100		100	
21		Hair		Hair		100		100	
22		Skins		Skins		100		100	
23		Leather		Leather		100		100	
24		Fur		Fur		100		100	
25		Bones		Bones		100		100	
26		Tallow		Tallow		100		100	
27		Horn		Horn		100		100	
28		Hoof		Hoof		100		100	
29		Manure		Manure		100		100	
30		Blood		Blood		100		100	
31		Hair		Hair		100		100	
32		Skins		Skins		100		100	
33		Leather		Leather		100		100	
34		Fur		Fur		100		100	
35		Bones		Bones		100		100	
36		Tallow		Tallow		100		100	
37		Horn		Horn		100		100	
38		Hoof		Hoof		100		100	
39		Manure		Manure		100		100	
40		Blood		Blood		100		100	
41		Hair		Hair		100		100	
42		Skins		Skins		100		100	
43		Leather		Leather		100		100	
44		Fur		Fur		100		100	
45		Bones		Bones		100		100	
46		Tallow		Tallow		100		100	
47		Horn		Horn		100		100	
48		Hoof		Hoof		100		100	
49		Manure		Manure		100		100	
50		Blood		Blood		100		100	
51		Hair		Hair		100		100	
52		Skins		Skins		100		100	
53		Leather		Leather		100		100	
54		Fur		Fur		100		100	
55		Bones		Bones		100		100	
56		Tallow		Tallow		100		100	
57		Horn		Horn		100		100	
58		Hoof		Hoof		100		100	
59		Manure		Manure		100		100	
60		Blood		Blood		100		100	
61		Hair		Hair		100		100	
62		Skins		Skins		100		100	
63		Leather		Leather		100		100	
64		Fur		Fur		100		100	
65		Bones		Bones		100		100	
66		Tallow		Tallow		100		100	
67		Horn		Horn		100		100	
68		Hoof		Hoof		100		100	
69		Manure		Manure		100		100	
70		Blood		Blood		100		100	
71		Hair		Hair		100		100	
72		Skins		Skins		100		100	
73		Leather		Leather		100		100	
74		Fur		Fur		100		100	
75		Bones		Bones		100		100	
76		Tallow		Tallow		100		100	
77		Horn		Horn		100		100	
78		Hoof		Hoof		100		100	
79		Manure		Manure		100		100	
80		Blood		Blood		100		100	
81		Hair		Hair		100		100	
82		Skins		Skins		100		100	
83		Leather		Leather		100		100	
84		Fur		Fur		100		100	
85		Bones		Bones		100		100	
86		Tallow		Tallow		100		100	
87		Horn		Horn		100		100	
88		Hoof		Hoof		100		100	
89		Manure		Manure		100		100	
90		Blood		Blood		100		100	
91		Hair		Hair		100		100	
92		Skins		Skins		100		100	
93		Leather		Leather		100		100	
94		Fur		Fur		100		100	
95		Bones		Bones		100		100	
96		Tallow		Tallow		100		100	
97		Horn		Horn		100		100	
98		Hoof		Hoof		100		100	
99		Manure		Manure		100		100	
100		Blood		Blood		100		100	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 1 8

REG. NO.

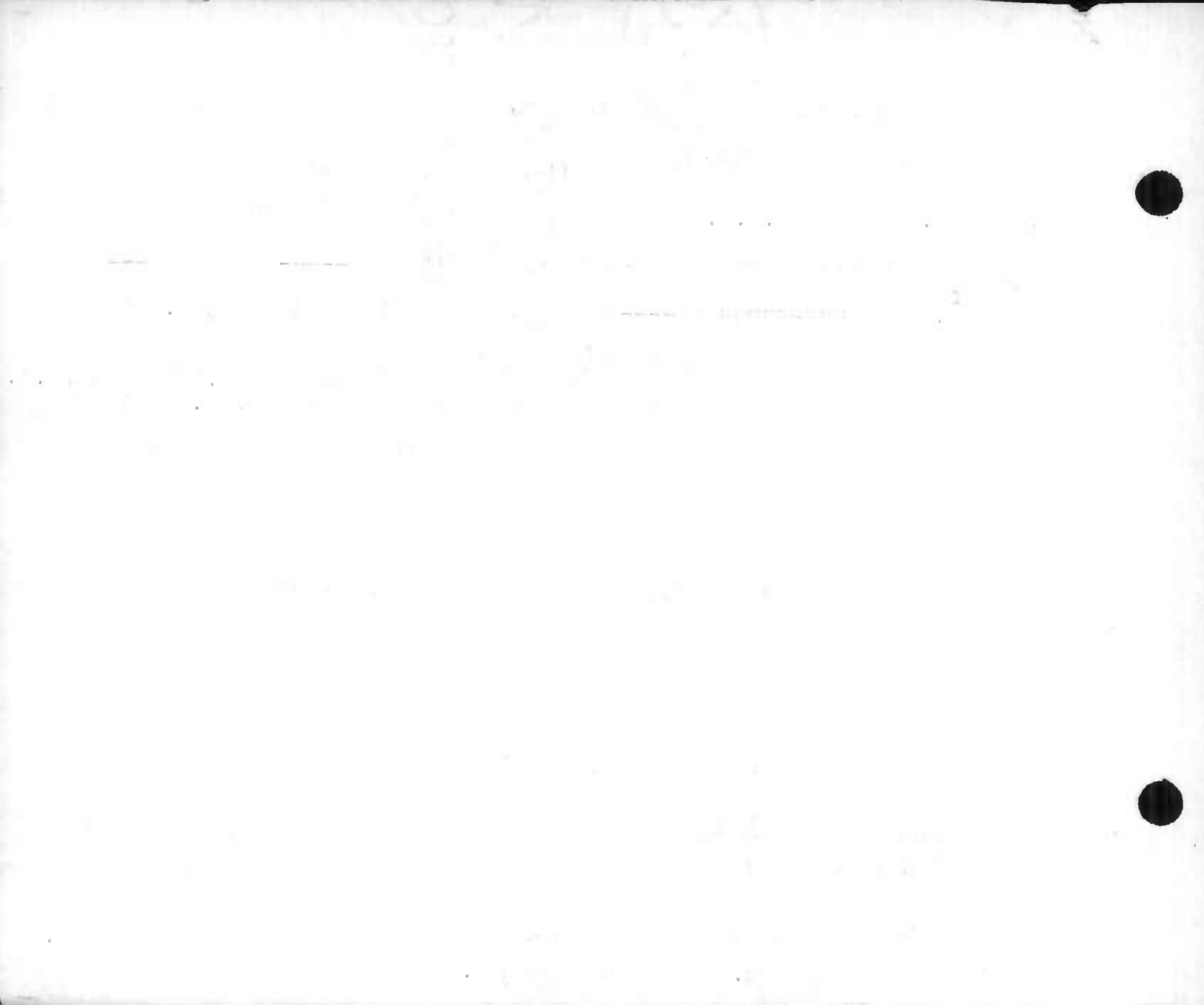
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CATHERINE HERBST			2a. DATE OF DEATH MONTH DAY YEAR 12 14 84			2b. HOUR 8:30 A			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR D3 10 - 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. STATE MD.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE ? Washington St./21231	
14. FATHER'S NAME FIRST MIDDLE LAST George Herbst				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT Kirstalane, Rd. 1/Box 103, A.A. Evelyn EreK Dallastown, Pa. 17313					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE DEHYDRATION, ELECTROLYTE DUE TO, OR AS A CONSEQUENCE OF (b) IMBALANCE DUE TO, OR AS A CONSEQUENCE OF (c) IMBALANCE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) URINARY TRACT INFECTION, CACHEXIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-10 19 84 to 12-14 19 84 , that (I) (we) lost saw the deceased alive on 12-13 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Tasneem Lakhani				DEGREE MD		22c. DATE SIGNED 12/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TASNEEM LAKHANI				22e. ADDRESS 9101 Old Court Rd, BALTIMORE MD 21233			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.				25a. DATE REC'D. BY REGISTRAR DEC 14 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 1 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELWOOD JOHN HERSTER				2a. DATE OF DEATH MONTH DAY YEAR December 16, 1984		2b. HOUR 2:20 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 15, 1917		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Timonium		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 32 Greenmeadow Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS OR INDUSTRY A.A.I. Corp.	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium	
14. FATHER'S NAME FIRST MIDDLE LAST William John Herster				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Naomi Hontz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 183-07-7320		17. INFORMANT ADDRESS Mrs. Caroline R. Herster, same as #13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma 20 to</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASCVD S/P CABG</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (old) (did not) view the body after death.							
22b. SIGNATURE <u>M. Cohen</u> DEGREE _____				22c. DATE SIGNED _____		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miriam L. Cohen, M.D.	
22e. ADDRESS 201 E. University Pkwy. Balto. Maryland				22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-17-84		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D BY REGISTRAR DEC 20 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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Handwritten notes and a table at the top of the page. The table has several columns and rows, with some text written inside. The handwriting is cursive and somewhat faded.

Handwritten notes and a table at the bottom of the page. The table has several columns and rows, with some text written inside. The handwriting is cursive and somewhat faded.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 2 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY TAYLOR HESKY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 29, 1984		2b. HOUR A M 11:00 A			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1922		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS. MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1511 Long Quarter Ct.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor		12b. KIND OF BUSINESS OR INDUSTRY College	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST CLARKSON C TAYLOR				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cheney Ketcher Farnock				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 291-22-3396		17 INFORMANT Gerhardt Hesky		ADDRESS Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung Metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Pulmonary Emphysema								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 1984 , to December 1984 , that (I) (we) last saw the deceased alive on 12/24/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE Dennis Whitehouse		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/29/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS WHITEHOUSE				22e. ADDRESS 6422 SHERWOOD ROAD BALTIMORE MD 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland		
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21211				25a. DATE REC'D. BY REGISTRAR JAN 2 1985				

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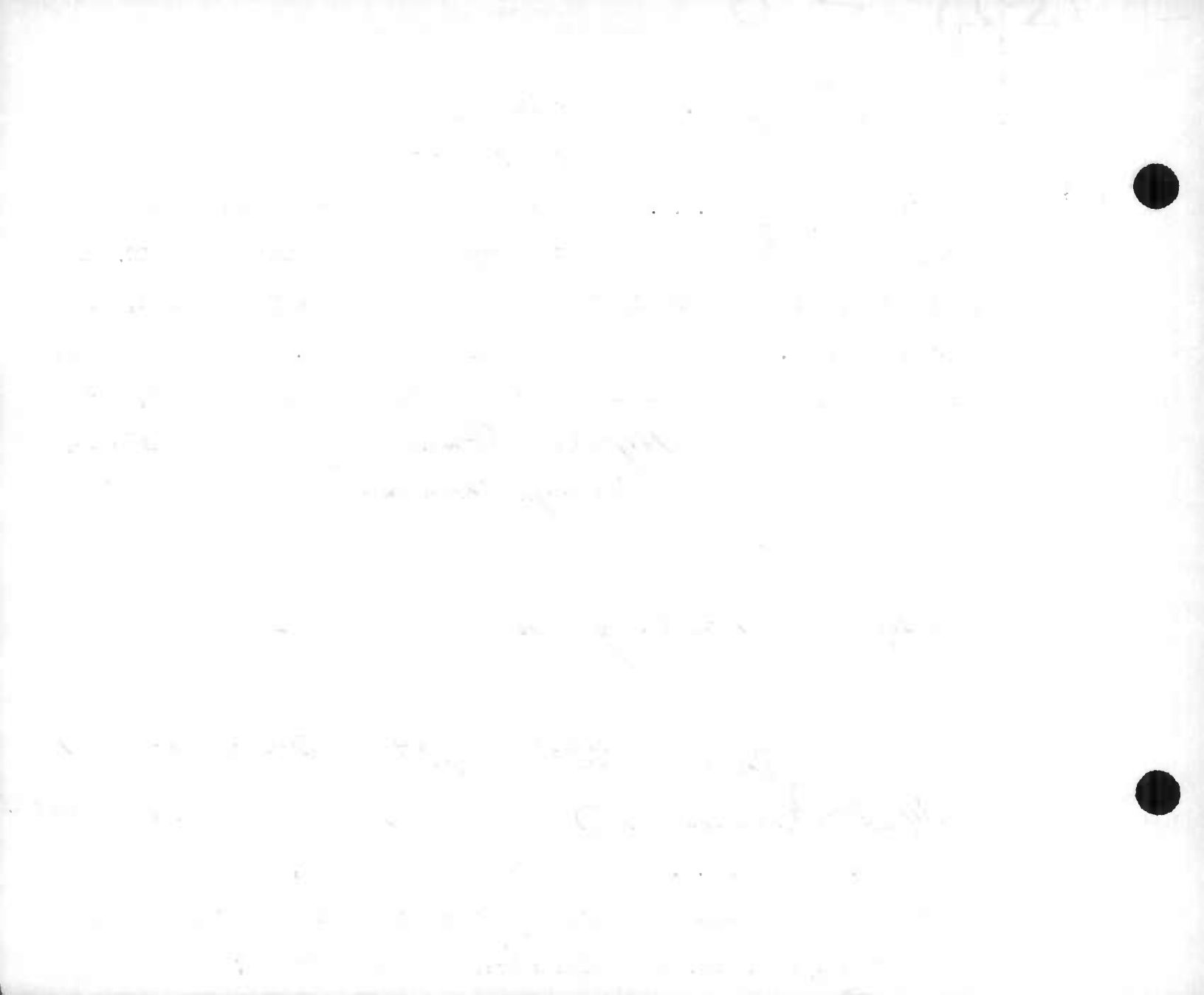
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 REG. NO.	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) ALICE M. HEYING						2a. DATE OF DEATH MONTH DAY YEAR 12 12 84		2b. HOUR 10:05A _M	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 06 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10 CITY OR TOWN OF DEATH HALETHORPE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 75 Colony Hill Court 21227						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN HALETHORPE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 75 COLONY HILL COURT, 21227			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN M. O'BRIEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE S. GRISSETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-3164		17 INFORMANT ADDRESS GLADDIS RAU 75 COLONY HILL COURT, 21227							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cholangia Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 11/20/		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/12/</u> 19 <u>84</u> to <u>Dec 3</u> 19 <u>84</u> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <u>Dec 3</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <input checked="" type="checkbox"/> saw the body after death.											
22b. SIGNATURE <u>Alfred S. Garrison</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Dec 12, 1984			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ALFRED S. GARRISON, M.D.				22e. ADDRESS 3455 WILKENS AVENUE, 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-15-84		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND					
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR 21229 DEC 13 1984		25b. REGISTRAR'S SIGNATURE <u>Jana Davidson-Hendell</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 2 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GUY Lee HICHEW			2a. DATE OF DEATH MONTH DAY YEAR 12 16 84		2b. HOUR 9:30AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7-27-1916		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 68 yrs. YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		12b. KIND OF BUSINESS OR INDUSTRY American Can		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 9506 Gunview Road 21236								
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Hichew				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Guy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS 21234		17. INFORMANT ADDRESS 3327 Summit Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE SECONDARY TO DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 84 , to 12-16 , 19 84 , that (I) (we) last saw the deceased alive on 12-15 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Timothy O'Donnell</i> DEGREE MD.				22c. DATE SIGNED 12-16-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Timothy O'Donnell M.D.				22e. ADDRESS GBMC 6701 N. CHARLES ST., TOWSON MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-19-84		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Handell</i>		
24. FUNERAL DIRECTOR ADDRESS 9705 Belair Road, Balto., Md.				25c. REGISTRAR'S SIGNATURE				

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DATE: 1-1-71

11-2

RESPIRATORY FAILURE SECONDARY TO
SEVERE EMPHYSEMA

1-1-71

11-2

1-1-71

1-1-71

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 2 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
HAROLD H. HOFFMAN Jr.		12 25 1984		11:14 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
MALE	White	5 MONTH 1 DAY 1926	58	MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8b. CITIZEN OF WHAT COUNTRY?	8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	U.S.A.		Baltimore, County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Towson	159 Versailles Circle 21204		Disabled		Disabled
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	
Maryland	Balto.	Towson		159 Versailles Circle 21204	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST Harold H. Hoffman Sr.			FIRST MIDDLE LAST Dorothy Newberger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		102-20-1201	10463 Arthur Hoffman-2635 Netherland Ave. Bronx, N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIAC FAILURE					
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOVASCULAR DISEASE					2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 72 to 12-25 84, that (I) (we) lost		22b. SIGNATURE Samuel Blumenfeld M.D. DEGREE			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL BLUMENFELD M.D.		22d. ADDRESS 500 PLATT HOSPITAL - 21204		22e. DATE SIGNED 12-25-84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-84		23c. NAME OF CEMETERY OR CREMATORY Salem Field Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Queens Queens N.Y.		23e. DATE REC'D. BY REGISTRAR DEC 27 1984		23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
24. FUNERAL DIRECTOR NAME Ruck-Towson Funeral Home Inc. ADDRESS 1050 York Rd. 21204					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (see instructions on page 4).

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 2 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy S. Holland			2a. DATE OF DEATH MONTH DAY YEAR 12 12 84			2b. HOUR 12:15 P M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 05 28 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center Catonsville				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Nurse Supervisor		12b. KIND OF BUSINESS OR INDUSTRY School System		
13a. STATE New Jersey			13b. COUNTY Middlesex		13c. CITY OR TOWN Highland Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 105 Lincoln Ave. 08904	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Stevens			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 136-30-0326		17. INFORMANT ADDRESS Robert Holland 1405 Hollins Street, 21223					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD w/ severe Peripheral Vascular</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Insufficiency - Cerebral Vascular insufficiency</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>na</u>			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE JOHN H. SHAW, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Shaw		22e. ADDRESS 5800 EDMONDSON AVE BALTIMORE, MD 21223					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL		23b. DATE 12-15-84		23c. NAME OF CEMETERY OR CREMATORY FRANKLIN MEMORIAL PK.		23d. LOCATION CITY OR TOWN COUNTY STATE NEW BRUNSWICK MIDDLESEX N.J.	
24. FUNERAL DIRECTOR NAME BALTO., MD. ADDRESS 21229 HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR DEC 13 1984			
				25b. REGISTRAR'S SIGNATURE Jana Davidson-Rendall			

(1)

6-20-20

6-20-20

6-20-20

6-20-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a report obtained.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 1 2 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Melvin J. Holland				2a. DATE OF DEATH MONTH DAY YEAR 12 20 85			
3 SEX MALE		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11 02 90		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10 CITY OR TOWN OF DEATH Baltimore, County		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTPOINT Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY Md. Drydock	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Noah Holland		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Griffie Dize		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b SOCIAL SECURITY NO. 218-01-9132	
17 INFORMANT ADDRESS William Holland Box 382 Delta, Pa.		17314					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Ca. of stomach				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Dec. 4, 19 84, to Dec. 20, 19 84, that (I) (we) last saw the deceased alive on Dec. 19, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE B. MATOS		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/21/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. MATOS		22e ADDRESS 21 CRANBROOK RD. COCKEYSVILLE MD. 21030					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/24/84		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24 FUNERAL DIRECTOR NAME Connelly Funeral Home of Dundalk		ADDRESS		25a DATE REC'D. BY REGISTRAR DEC 28 1985		25b REGISTRAR'S SIGNATURE John A. Davidson - Dundalk	

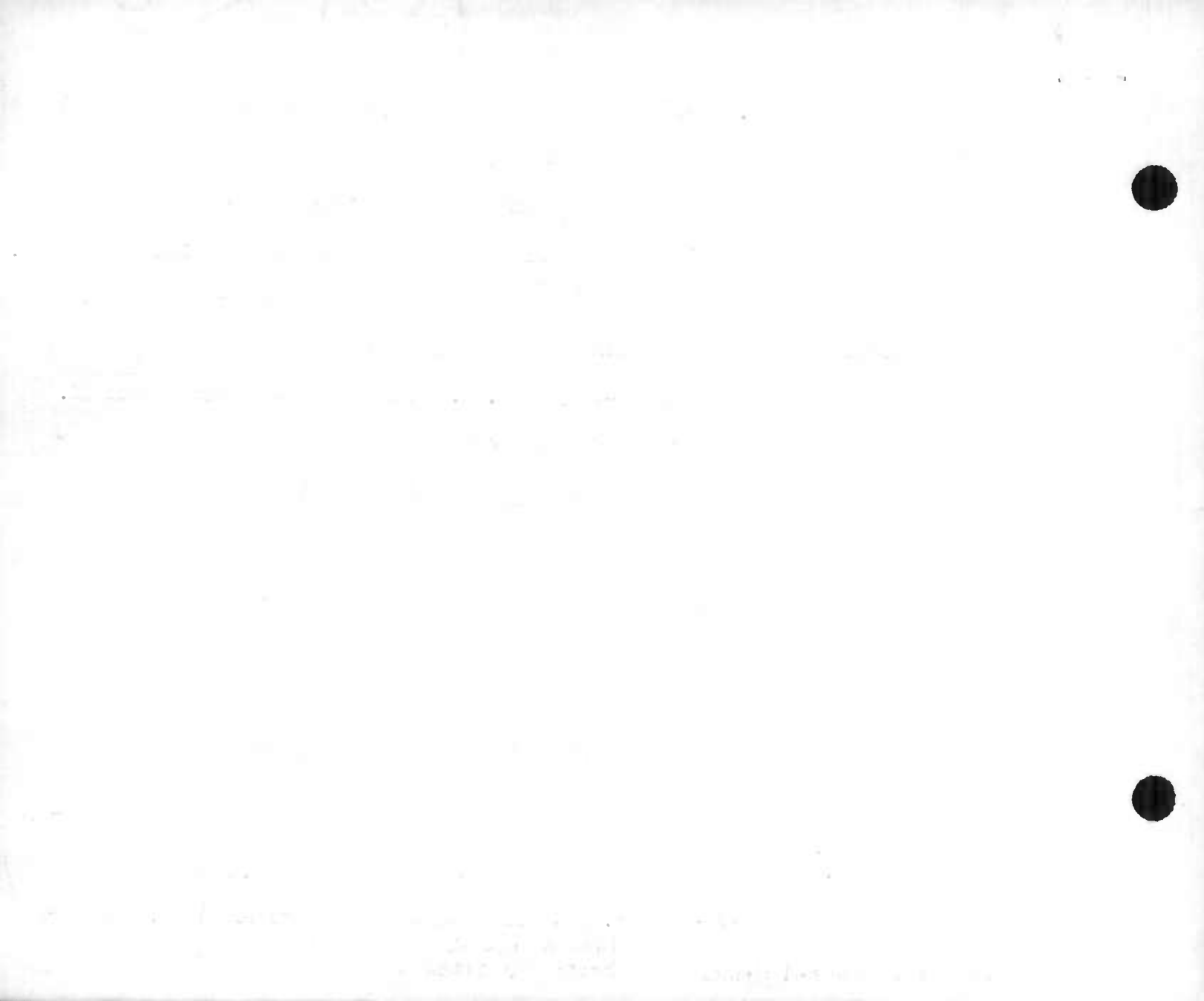
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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 2 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen M. HOLTHAUS			2a. DATE OF DEATH MONTH DAY YEAR December 13, 1984			2b. HOUR 8:25 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 7 04		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Kroger Shoe Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN 6706 Linden Avenue		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Beltz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth N/A			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
16b. SOCIAL SECURITY NO. 212-09-1943			17. INFORMANT Wm. C. Smith			ADDRESS 4956 Buck School House Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 18, 1984 , to December 13, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 13, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE Albert K. Lee, MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12.13.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert K. Lee, MD			22e. ADDRESS 9000 Franklin Square Dr., 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-17-84		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		
24. FUNERAL DIRECTOR NAME Hassahn Funeral Home			ADDRESS 1401 Belair Rd. BALTO. MD. 21236		25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 2 1

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Otto J Holzschuh			2a. DATE OF DEATH MONTH DAY YEAR 12-7-84		2b. HOUR 1:25pm		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 8, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital		12a. USUAL OCCUPATION (TYPICAL WORK OF MOST OF LIFE WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Holzschuh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ? ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 214-18-3638		17. INFORMANT ADDRESS Carol - Linda Brown 4328 Silver Spring Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LEFT LUNG DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULM. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) MANY YEARS.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CONGESTIVE HEART FAILURE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-1 , 19 84 , to 12-7 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-7 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EAGAN, JR., MD.				22e. ADDRESS 7620 York Road Towson Md 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 10 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called within 24 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 1 2 8	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Alice C. HONIG		December 29, 1984		2:15 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	4-21-1888	96 yrs.	MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Franklin Square Hospital		Cleaning Lady		Social Sec.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE	
Md.		Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3915 Lyndale Avenue 21213	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Charles Rosensteel		Catherine Murphy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no		217-34-4206	Helen C. Vick same address as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Dehydration					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Probable sepsis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-21-84, to 12-29-84, that (X) (we) last saw the deceased alive on 12-29-84, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Carol A. Gosnell M.D.				12/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Carol A. Gosnell, M.D.		9000 Franklin Square Drive		21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
Burial		12-31-84	Moreland Mem. Park	Balto., Md.	
24. FUNERAL HOME (NAME)		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Schnitzler Funeral Home, Inc.		JAN 2 1985		na Davidson-Randall	
3331 Brehms Lane, Balto., Md. 21213					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

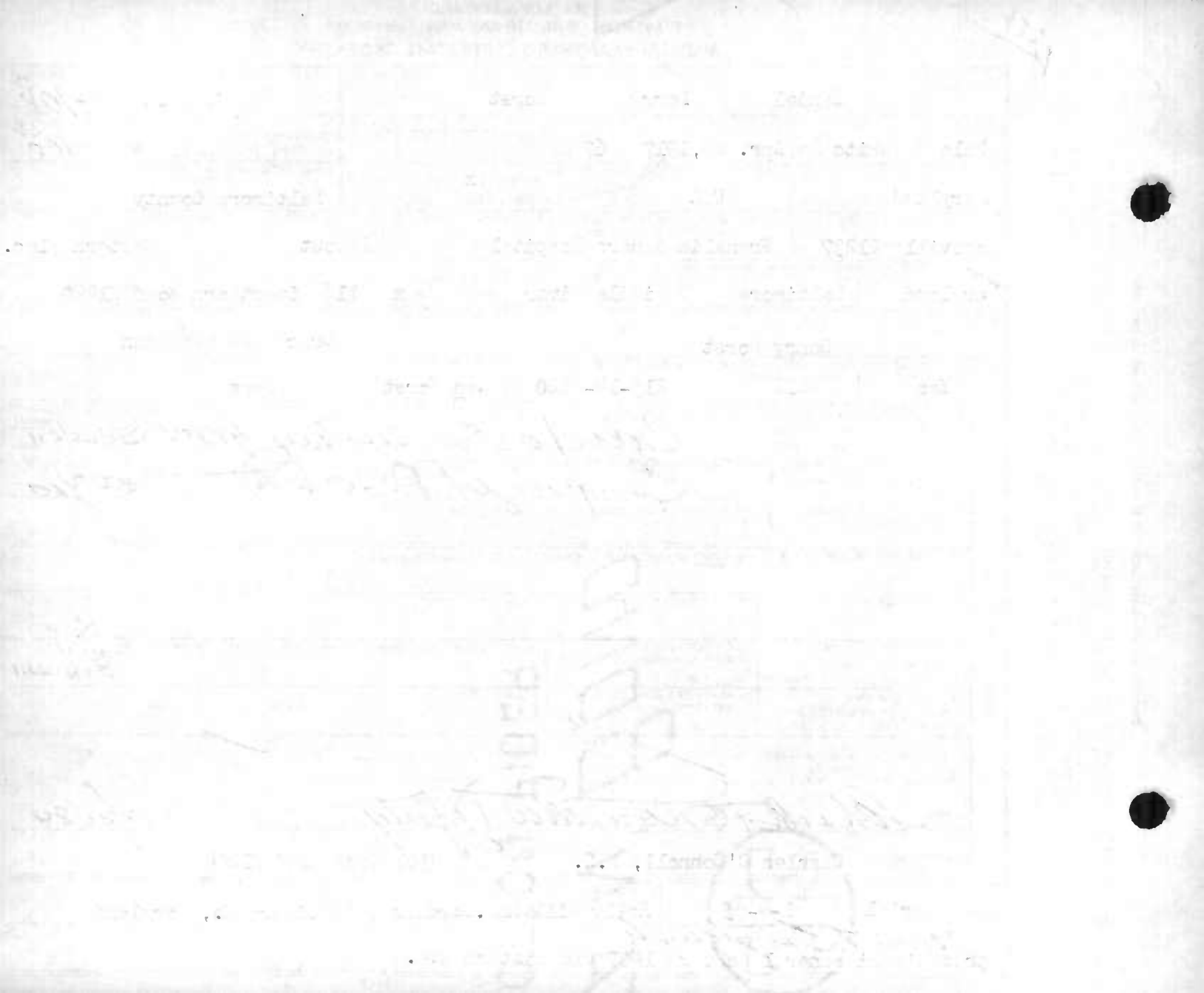
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Daniel Perry Horst			20. DATE KNOWN OF DEATH ESTIMATED December 30, 1984		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr. 28, 1917	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7. DATE PRONOUNCED DEAD December 30, 1984
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Layout	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS 116 Riverthorn Road 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Horst			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Mae Eshelman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATE OF BIRTH) 215-14-2820		17. INFORMANT Ann Horst	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions: if any, which gave rise to immediate cause (a) stating the underlying cause last.		Cardio Respiratory Arrest Sudden Generalized ASCVD 35 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 35 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Family Permission	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Charles O'Donnell, M.D.		TITLE (SPECIFY) Deputy		DATE SIGNED 12/31/84	
EXAMINER'S NAME (TYPE OR PRINT) Charles O'Donnell, M.D.		ADDRESS 7501 York Road 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co, Maryland		25a. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave		25b. REGISTRAR'S SIGNATURE JAN 3 1985			



MEDICAL CERTIFICATION

DHMH - 16 50M 4/B2
(VRA 15, 4)

547-115

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

TO: DIRECTOR, BUREAU OF PLANT INDUSTRY
FROM: [illegible]
SUBJECT: [illegible]

[The following text is extremely faint and largely illegible, appearing to be a memorandum or report body.]

Wetner, M.D.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 1 3 1	
1. DECEASED NAME (TYPE OR PRINT) India Elizabeth Howard				2a. DATE OF DEATH MONTH DAY YEAR December 30, 1984	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 27 1907	
7a. BIRTHPLACE (STATE OR FOREIGN) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 77 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Upperco 21155		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3407 Fifth Avenue		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
12a. USUAL OCCUPATION (IF OTHER THAN USUAL, GIVE WORKING PLACE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		MD	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex	
14. FATHER'S NAME FIRST MIDDLE LAST Alger Vaught		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Texie Meadows		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 233 38 1460		17. INFORMANT ADDRESS Richard Carter, Nephew 1 Spring House Rd. Lutherville Md. 21099	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (ii) Bleeding duodenal ulcer, diabetes mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 10 yrs 30 yrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 52 , to 12/30 , 19 84 , that (I) (we) last saw the deceased alive on 12/24 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A.L. Kolodny		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.L. Kolodny MD		22e. ADDRESS FRANKLIN SQ. MED. ARTS			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/3/85		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
23d. LOCATION Baltimore Md.		COUNTY 21237		STATE	
24. FUNERAL HOME Brzezinski Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE Car Anderson-Pendall	

SECRET



SECRET

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

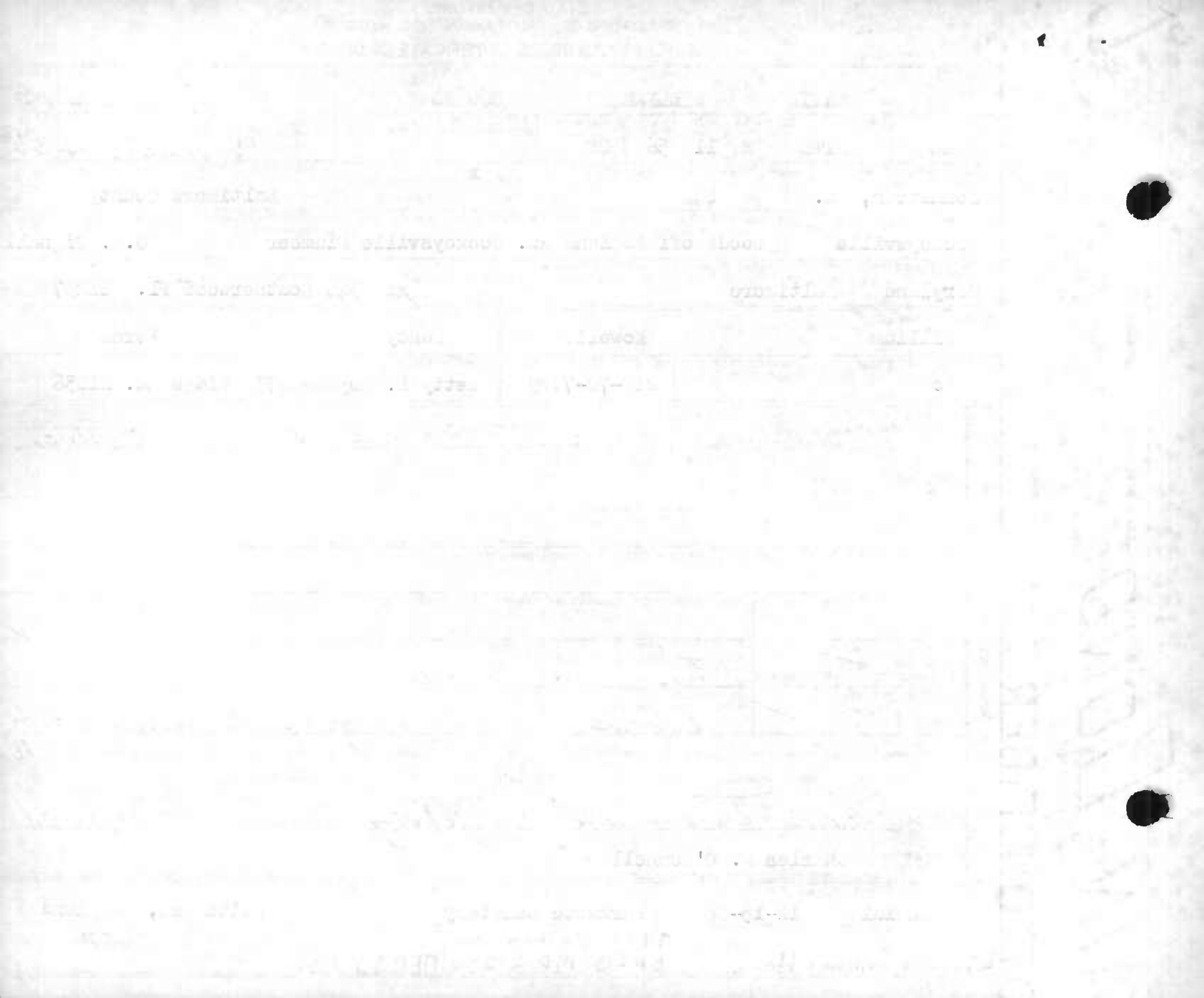
DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 1 3 2

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST DAVID		MIDDLE WILLIAM		LAST HOWELL		2a. DATE KNOWN OF DEATH ESTIMATED December 12, 84		MONTH DAY YEAR		2b. HOUR 1 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 11 56		6. AGE (IN YEARS) (LAST BIRTHDAY) 28 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD December 12, 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Johnstown, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		MD.		2d. HOUR 3 P.M.			
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Woods off Ashland Rd. Cockeysville		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY G.E. Tignall							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 340 Leatherwood Pl. 21237					
14. FATHER'S NAME FIRST William		MIDDLE		LAST Howell		15. MOTHER'S MAIDEN NAME FIRST Nancy		MIDDLE Kerns		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 212-70-7789		17. INFORMANT Betty D. Royahn		ADDRESS 4732 Ridge Rd. 21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Blast To Skull DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 1 P.M. Dec 12-1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 12 gauge Shotgun					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Woods				21f. LOCATION STREET Woods off Ashland Rd. Cockeysville		CITY OR TOWN Baltimore		COUNTY BALTO	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Charles F. O'Donnell				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 12/12/84	
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-15-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION CITY OR TOWN Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				ADDRESS 7401 Belair Rd. BALTO. MD. 21236				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE The Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 3 3
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN	
ESTELLE M. HUDSON		12-21-84		2 02 M	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Female	Black	MONTH DAY YEAR	67 YRS.	MONTHS DAYS HOURS MIN	
2. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U. S. A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Baltimore County General Hospital		Assembly Worker		Bata Shoe
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
Maryland		Harbor	Baltimore	2808 Clifton Ave. Baltimore, Maryland 21216	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Doc		Blanche		No.	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		Harriet Green		6800 Liberty Road Apt. 909 Baltimore, Maryland 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). CARDIO RESPIRATORY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b). ACUTE MYOCARDIAL INFARCTION					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c). RESPIRATORY FAILURE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC CHRONIC PULMONARY DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-19-84 to 12-21-84, that (I) (we) last saw the deceased alive on 12-21-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		DEGREE		12-21-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ORLANDO B. CONNAN MD.		BETH - RANDALLTOWN Md. 21132			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/27/1984		Cedar Hill Cemetery	
24. FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Nutter & Sons		DEC 31 1984		~ ~ ~ ~ ~ Randell	
26. FUNERAL HOME INC. BALTIMORE, MARYLAND 21216					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

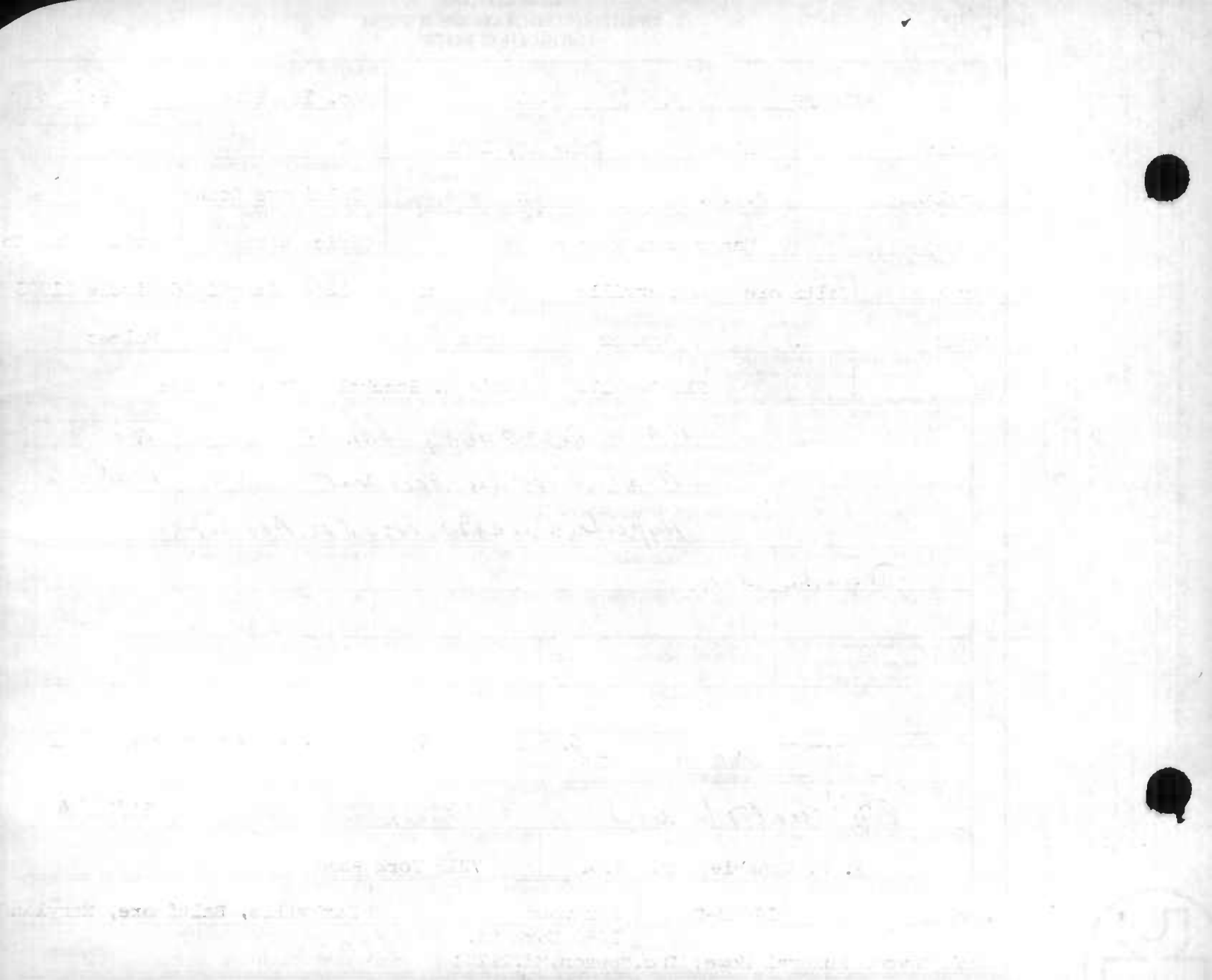
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 3 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILDRED E. HULL			2a. DATE OF DEATH MONTH DAY YEAR Dec. 19, 1984		2b. HOUR 5:20 p.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Towson				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Worker		
12b. KIND OF BUSINESS OR INDUSTRY American Can Co								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS 1244 Clearfield Circle 21093								
14. FATHER'S NAME FIRST MIDDLE LAST Frank G. Kramer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Holmes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-38-1172		17. INFORMANT ADDRESS Doris H. Steckel - Same as #13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive CARDIOVASCULAR Accident</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1916</u> <u>weeks</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Decubitus ulcer</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-19-66</u> to <u>12-19-84</u> that (I) was lost saw the deceased alive on <u>Dec 11, 1984</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) did not view the body after death.								
22b. SIGNATURE <u>S. J. Venable, Jr., M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. J. Venable, Jr., M.D.				22e. ADDRESS 7215 York Road				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-clippers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 3 5
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		DEC. 21, 1984		7:55 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		JULY 12, 1900		84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
RUSSIA		USA				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PIKESVILLE		PIKESVILLE NURSING HOME		HOUSEWIFE		AT HOME	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		BALTO.		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
HYMAN		CELIA		6731 CHISHOLM DR. #21207			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
NO		220-44-9147T		MRS. ESTHER LEVY		6731 CHISHOLM DR. (21207)	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal cancer with</u> DUE TO, OR AS A CONSEQUENCE OF <u>tracheal fistula</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (b) <u>Constrictive heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>81</u> to <u>12-21</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>early Dec</u> 19 <u>84</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (said and) not view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Harold Bob</u>		MD				12-22-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
HAROLD BOB, MD		2400 SHELLEYDALE DR. BALTO., MD 21209					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		12/24/84		KNESSETH ISRAEL		ANNAPOLIS ANNE ARUNDEL MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		DEC 28 1984		<u>Julia Davidson</u>			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 6
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Agnes Rose HUTCHINSON			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1984		2b. HOUR 11:15 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 10, 1894	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Towson Convalescent Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker	12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2412 Ellis Road 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Hilmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances V. Kaupp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. -----	17. INFORMANT ADDRESS William J. Hutchinson, 2412 Ellis Rd. Balto, Md. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis + Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASWD + CBS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASWD + CBS</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>10/1</u> , 19 <u>84</u> , to <u>12/12</u> , 19 <u>84</u> , that (I) (we) (us) saw the deceased alive on <u>12/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Richard Maffezzoli, M.D.</u>		DEGREE <u>M.D.</u>	22c. DATE SIGNED Dec 13, 84		22d. ADDRESS 660 Kenilworth Dr. Towson, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE Dec 15, 84	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc.		ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1984	25b. REGISTRAR'S SIGNATURE <u>John Davidson Kendall</u>

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified by once.

MEDICAL CERTIFICATION

2
9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified by once.

No.	Name of Plant	Origin	Collector	Date	Locality	Remarks
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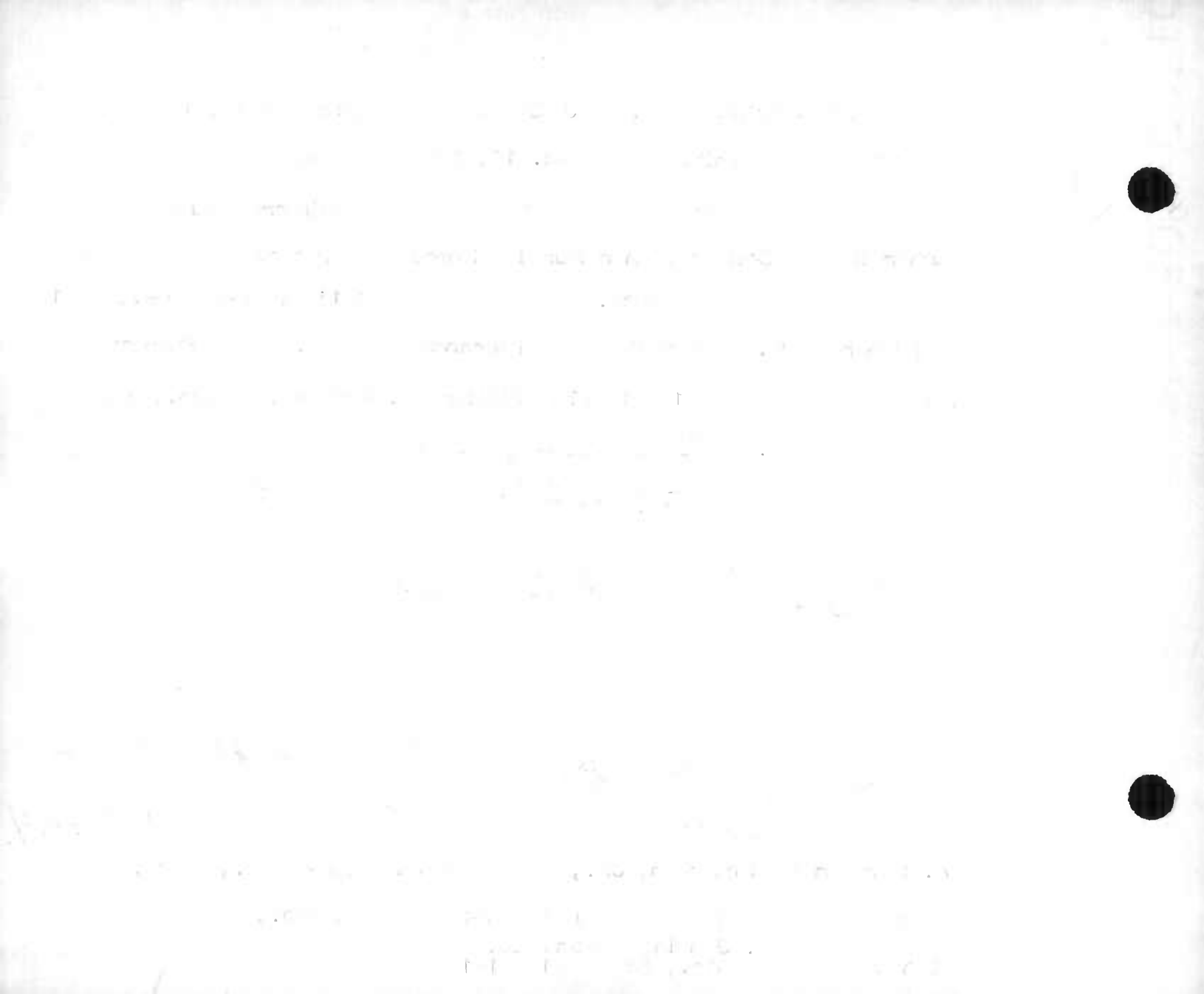
CHIEFMAN



REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST FLORENCE		MIDDLE D.	LAST JACOBS		2a. DATE OF DEATH MONTH DAY YEAR December 12, 1984		2b. HOUR 7:00		a.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1985		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD							
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) College Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Banking					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4811 Crowson Ave., 21212			
14. FATHER'S NAME FIRST MIDDLE LAST Richard F. Duvall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence E. Starling									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 01 2975		17. INFORMANT ADDRESS William C. Bordley, Balto., MD									
11. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>A-S-C-V. disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2hr</u> <u>5y</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Myo thyroid disease</u>													
19a. DATE OF OPERATION <u>12/12/84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u></u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) <u></u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u></u>									
22a. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> 19 <u>53</u> to <u>12/12</u> 19 <u>84</u> that (I) <u>(u)</u> lost saw the deceased alive on <u>11/21</u> 19 <u>84</u> and that in (my) <u>u</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(u)</u> (did not) view the body after death.													
22b. SIGNATURE <u>Norman R. Freeman, Jr.</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/13/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Norman R. Freeman, Jr.				22e. ADDRESS MD 4300 N. Charles St., Balto., MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park				23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD MD					
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD						25a. DATE REC'D BY REGISTRAR DEC 13 1984		25b. REGISTRAR'S SIGNATURE <u>Richard Handall</u>					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 3 8
REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ressa Mae Jacobson			2a. DATE OF DEATH MONTH DAY YEAR 12 13 84			2b. HOUR 445 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 21 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wyoming		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.	
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) College Manor Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Glen Arm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Darwin Meacham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Rogers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 552-30-1052		17. INFORMANT ADDRESS Dr. Wayne E. Jacobson - Same as #13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>asthma, emphysema</i>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Chronic brain Syndrome*

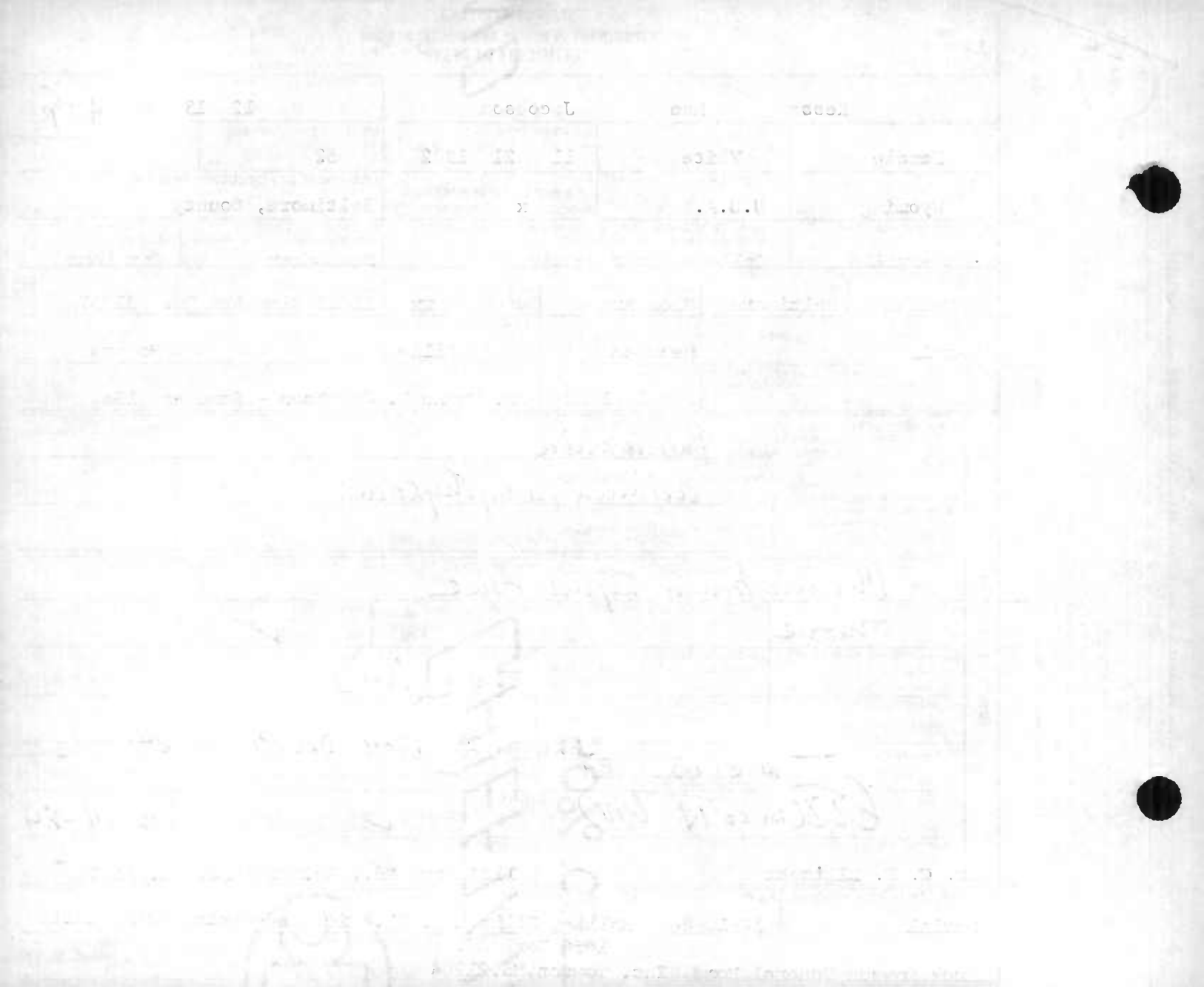
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>No injury</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>January 23</i> 19 <i>1984</i> to <i>Dec 13</i> 19 <i>84</i> that (I) (we) lost saw the deceased alive on <i>Dec 13</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death.							
22b. SIGNATURE <i>Dr. C. E. Ellicott</i>				DEGREE		22c. DATE SIGNED <i>12-14-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. E. Ellicott				22e. ADDRESS 1134 York Rd., Lutherville, Md. 21093			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-18-84		23c. NAME OF CEMETERY OR CREMATORY Rolling Hills Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond-Contra Costa, Calif	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 3 9

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>SADYE</i>			FIRST MIDDLE LAST <i>JACOBSON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 6 1984</i>			2b. HOUR <i>3230 AM</i>		
3. SEX <i>Female</i>			4. RACE <i>white</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>10 16 1905</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County, MD</i>		
10. CITY OR TOWN OF DEATH <i>Randallstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SALESLADY</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>DEPT. STORE</i>		
13a. STATE <i>Maryland</i>			13b. CITY OR TOWN <i>Baltimore</i>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS / ZIP CODE <i>133 slope Ave 21205</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>SOLOMON LURIE</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>HANNAH COHEN</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>218-09-2140</i>		
17. INFORMANT <i>MRS. JOSEPH HARRIS</i>			APT. F2 <i>3651 GLENGYLE AVE. BALTO., MD 21215</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asystolic cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>multiple medical problems</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Possible Sepsis, Possible pulmonary embolism</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11-27</i> , 19 <i>84</i> , to <i>12-6</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12-6</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Steven Steinberg</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12/6/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEVEN STEINBERG</i>			22e. ADDRESS <i>3502 CROYDON RD Baltimore</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>DEC. 9, 1984</i>			23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW YOUNG MEN</i>			23d. LOCATION <i>BALTIMORE</i> COUNTY <i>MARYLAND</i>		
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i> <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 12 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Randall</i>		

BP



FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank Harmon Jacoby			2a. DATE OF DEATH MONTH DAY YEAR 12 12 84			2b. HOUR 5:20 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 5 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7102 Maple Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Loftsman	
12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Shipyard							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 7102 Maple Drive 21222							
14. FATHER'S NAME FIRST MIDDLE LAST Edward A. Jacoby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Dulin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-1480		17. INFORMANT ADDRESS Helen J. Jacoby Same as Line 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 3 1983 to Dec 12 1984 , that (I) (we) lost saw the deceased alive on Dec 12 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David P. Zajano				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David P. Zajano, M.D.				22e. ADDRESS 9000 Franklin Square Drive. 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall	

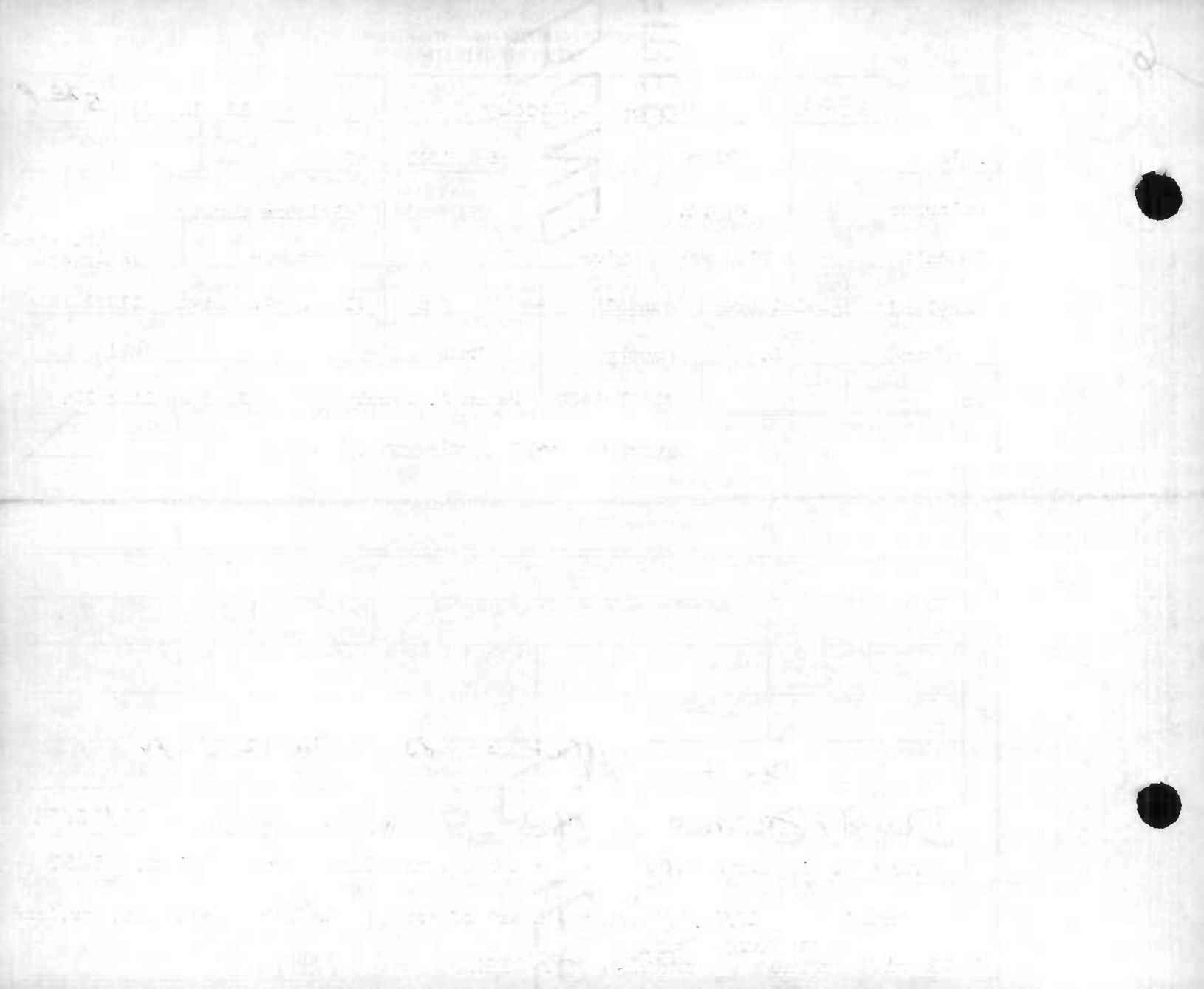
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 4 1

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Marian R Janeczek			2a. DATE OF DEATH MONTH DAY YEAR 12 13 84			2b. HOUR 1:40 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 10 17		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWKE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JESSE LEE MORGAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE KODER			13e. STREET ADDRESS / ZIP CODE 1736 OAKLAC RD 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 170 301548		17. INFORMANT ADDRESS EUGENE JANECEK ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> 19 <u>84</u> to <u>12/13</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Rester A. Wall Jr.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RESTER A. WALL JR.			22e. ADDRESS 7620 York Rd Towson Md 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL-BURIAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY JENNER CROSS		23d. LOCATION CITY OR TOWN COUNTY STATE BOSWELL PA		
24. FUNERAL DIRECTOR NAME J.G. CONNELLY			ADDRESS 300 MACE			25a. DATE REC'D BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text on lined paper, appearing to be a letter or document. The text is mirrored across the page, suggesting it was written on the reverse side. The handwriting is cursive and somewhat faded. The text is mostly illegible due to the quality of the scan and the mirroring effect.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 4 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elizabeth <i>MMW</i> JENKINS			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1984		2b. HOUR P 2:15 M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR 11-7-1925	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Balto. Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Rossville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Franklin Square Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Never Employed</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Md.</i>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13c. CITY OR TOWN <i>Balto.</i>		13d. STREET ADDRESS, ZIP CODE <i>4300 Willshire Ave. -21206</i>			
14. FATHER'S NAME <i>Warren M. Jenkins</i>			15. MOTHER'S MAIDEN NAME <i>Ethel B. Dobbs</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-03-6236</i>		17. INFORMANT ADDRESS <i>4300 Willshire Ave</i> <i>Mrs. Margaret B. Trojan Balto. Md. -21206</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bacterial Endocarditis involving mitral valve</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Status post mitral valve replacement</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Rheumatic Heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from <i>December 19 84</i> to <i>December 20 84</i> , that I (we) last saw the deceased alive on <i>December 20 19 84</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Paul L. Tecklenberg</i> MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul L. Tecklenberg, M.D.		22e. ADDRESS 9000 Franklin Square Drive, 21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12-24-84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>
24. FUNERAL DIRECTOR <i>John C. Miller Inc. 6415 Belair Rd. -21206</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 26 1984</i>	25b. REGISTRAR'S SIGNATURE <i>na Gordon Fordell</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

MEDICAL CERTIFICATION

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 4 3

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMILY M. JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR Dec. 4, 84		2b. HOUR 7 PM
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 17 07		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. Co. MD.		
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. Co. GEN'L		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Monkton	13c. STREET ADDRESS / ZIP CODE 17314 Big Falls Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST SHERMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA HALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-48-2338		17. INFORMANT ADDRESS YVONNE Smith 400 Gwynnwest Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>s. apoplexia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 23, 1984</u> to <u>Dec. 4, 1984</u> , that (I) (we) last saw the deceased alive on <u>Dec. 4, 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sharon Pountabed, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-4-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM Pountabed		22e. ADDRESS Balto. County Gen. Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/9/84	23c. NAME OF CEMETERY OR CREMATORY St. Lukes Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE HEREFORD Md.
24. FUNERAL DIRECTOR NAME CHATMAN-HARRIS FH		ADDRESS 1701 McCulloch St		25a. DATE REC'D. BY REGISTRAR DEC 10 1984	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of other.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified in writing.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 4 4 REG. NO.					
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY JOSEPH JOHNSON										2a. DATE OF DEATH MONTH DAY YEAR 12 28 84				2b. HOUR 9:53P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 14 1888		6. AGE (IN YEARS LAST BIRTHDAY) YRS 96		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		7b. HOUR 00					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD									
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARTIN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD							
13a. STATE MARYLAND		13b. CITY OR TOWN A.A.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 404 LAUREL ROAD, 21146									
14. FATHER'S NAME FIRST MIDDLE LAST HENRY J. JOHNSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN GROFF											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 705-09-8001		17. INFORMANT ADDRESS SISTER PAUL 601 MAIDEN CHOICE LANE, 21228											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) - Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 84 to 12/28 19 84 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE N. Ravendhran				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/29/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. RAVENDHRAN, M.D.				22e. ADDRESS c/o ST. MARTIN HOME, 21228											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND									
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE John Davidson							

BP

THE JAPANESE ATTEMPT TO DOMINATE THE
MIDDLE EAST



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Hetty S. Johnson		December 20, 1984		0006AM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 5 1896	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	7. HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manufacturer	12b. KIND OF BUSINESS OR INDUSTRY Garment		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Pikesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 101 Sherwood Ave. 21208
14. FATHER'S NAME FIRST MIDDLE LAST Everett Y. Sorden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada L. Baughman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 064-09-2292		17. ADDRESS 816 Olmstead Rd. Pikesville Maryland 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.					
22b. SIGNATURE Hafeez A. Syed		DEGREE MD		22c. DATE SIGNED 12/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEZ SYED		22e. ADDRESS BALTIMORE COUNTY GEN HOSP			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/22/84	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.			25a. DATE REC'D. BY REGISTRAR DEC 27 1984		
25b. REGISTRAR'S SIGNATURE Gelia Davidson-Randall					
26. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133					

6138 Laboratory for Forensic Medicine, Maryland 21138
 During the Forensic Medicine, Inc.
 12/22/74 Field Office Laboratory
 Baltimore, Maryland
 6138 Laboratory for Forensic Medicine, Maryland 21138

6138 Laboratory for Forensic Medicine, Maryland 21138
 During the Forensic Medicine, Inc.
 12/22/74 Field Office Laboratory
 Baltimore, Maryland
 6138 Laboratory for Forensic Medicine, Maryland 21138

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 6138 Laboratory for Forensic Medicine, Maryland 21138

6138 Laboratory for Forensic Medicine, Maryland 21138
 During the Forensic Medicine, Inc.
 12/22/74 Field Office Laboratory
 Baltimore, Maryland
 6138 Laboratory for Forensic Medicine, Maryland 21138

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 4 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Dastin JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR December 25, 1984			2b. HOUR 7:25 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 28, 1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 73		7. UNDER 1 YEAR HOURS MIN. 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Contractor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12 Parham Circle 21237	
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Partim			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 223-07-1113			17. INFORMANT ADDRESS Mr James L Johnson 240 Forrest Ave Elkins Park, Pa 19117						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest, Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **Ischemic Bowel Disease, Pseudomembranous**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Enterocolitis****Cardiac Failure**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that XX (this hospital) attended the deceased from December 8, 1984 to December 25, 1984 , that XX (we) last saw the deceased alive on December 25, 1984 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above.							
23a. SIGNATURE [Signature]				DEGREE		23c. DATE SIGNED 12-25-84	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. PETERSON				23d. ADDRESS 9000 Franklin Square Dr., 21237			

24. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		25a. DATE 12/29/84		25b. NAME OF CEMETERY OR CREMATORY Peninsula Mem. Park		25c. LOCATION CITY OR TOWN COUNTY STATE Newport News Virginia	
26. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland				27a. DATE REC'D. BY REGISTRAR DEC 27 1984			
				27b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR ROBERT FRANCIS JOHNSON

3 2 1 4 7
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT F JOHNSON			2a DATE OF DEATH MONTH DAY YEAR 12 27 84		2b HOUR 4⁵⁰ AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 5-9-24	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 60	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Randallstown	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool & Die Maker		12b KIND OF BUSINESS OR INDUSTRY Laneko Machine Corp.
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Baltimore		
13c CITY OR TOWN Woodlawn			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE 2003 Royal Garden Drive 21207					
14 FATHER'S NAME FIRST MIDDLE LAST Stephen E. Johnson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Beuhl		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17 INFORMANT Timothy R. Johnson	
		154-22-2301		ADDRESS Same as # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of Abdominal Aorta - DIC DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD - PERIPHERAL VASCULAR DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CORONARY ARTERY DISEASE - MYOCARDIAL INFARCTION					
19a DATE OF OPERATION 12/26/28		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Hypotension EMERGENCY LAPAROTOMY		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12-26 , 19 84 , to 12-27 , 19 84 , that (I) (we) last saw the deceased alive on 12-27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE R. DEPESTINE		DEGREE MD		22c DATE SIGNED 12/27/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) R. DEPESTINE		22e ADDRESS BALTIMORE COUNTY GENERAL HOSP.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/31/84		23c NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans Owings Mills	
				23d LOCATION CITY OR TOWN COUNTY STATE Md.	
24 FUNERAL DIRECTOR Leroy M. & Russell C. Witzke		25 DATE REC'D BY REGISTRAR DEC 27 1984		26 REGISTRAR'S SIGNATURE <i>[Signature]</i>	
1630 Edmondson Avenue, Catonsville, Md. 21228					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

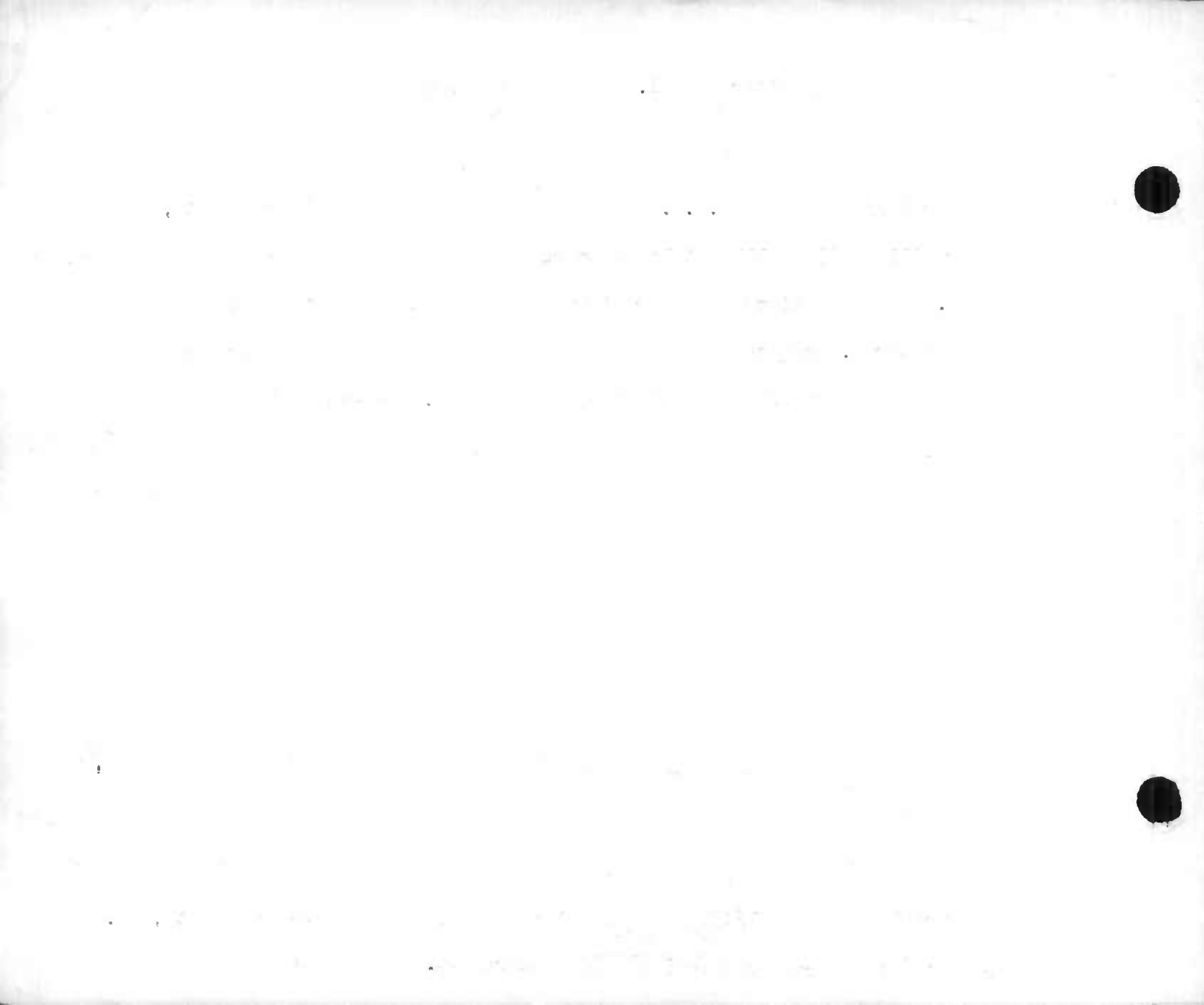
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 32148	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) WALTER THOMAS JOHNSON				2a. DATE OF DEATH MONTH DAY YEAR 12/26/84		2b. HOUR 6:40 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 11, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH Parkville 21234		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1315 Hillswat Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Glazer		12b. KIND OF BUSINESS OR INDUSTRY Construction			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1315 Hillswat Ct. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Walter T. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Metheny							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217-18-2808		17. INFORMANT ADDRESS Mabel L. Johnson (Wife)				Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest										5 months	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Transitional CAB/CA Bloodwork										7/84	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/18, 1984 to 12/26, 1984 that (I) (we) last saw the deceased alive on 12/26, 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE				22c. DATE SIGNED 12/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gwen Dubois MD				22e. ADDRESS 3900 Loch Raven Blvd 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.			
24. FUNERAL DIRECTOR Bruzdziński Funeral Home PA 1407 Old Eastern Ave.						25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					3 2 1 4 9 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) CORA MAE JONES					2a. DATE OF DEATH MONTH DAY YEAR December 8, 1984					2b. HOUR 3:30 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Maryland Line		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21431 York Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assemblyperson			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Maryland Line		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21431 York Road 21105			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas L. Holloway					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-12-3202		17. INFORMANT ADDRESS 21431 York Rd. William M. Jones, Maryland Line, MD 21105							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>10-4-</u> 19 <u>89</u> to <u>3-14-</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>10-4-</u> 19 <u>89</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard Robinson, M.D.</u> DEGREE								22c. DATE SIGNED 12-8-84		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD ROBINSON					22e. ADDRESS New Freedom Pa. 17349						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Line Cem. Maryland Line, Balto. MD			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR J. J. Hartenstein, New Freedom, PA 17349											

BP



CHIEF

20th OCT 1941

20th OCT 1941

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Jessie Cook Jones		MONTH DAY YEAR 12 21 84		5:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR 1 16 1884	100 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	Baltimore		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Armcast Nursing Home	Housewife	Homemaker		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Md.	Baltimore	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Balto., Md. 812 Register Avenue, 21212	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Valentine Cook		FIRST MIDDLE LAST Martha Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-05-9974		21093 Mr. Milton Jones, 2005 Eastridge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Generalized ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10± yrs</u>
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>12 December 84</u> to <u>21 December 84</u> , that (I) (we) most saw the deceased alive on <u>9 December 19 84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you (we) did not view the body after death, so state.)					
22b. SIGNATURE OF PHYSICIAN				22c. DATE SIGNED	
<u>Charles F. O'Donnell</u>				<u>12/21/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Charles F. O'Donnell, M. D.				7501 York Road	
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/22/84		Woodlawn Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Balto. Md.	
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)				25a. DATE REC'D. BY REGISTRAR	
Lennon-Mitchell-Wiedefeld, 10 W. Padonia				DEC 24 1984	
				25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 1 5 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Moses JONES				2a. DATE OF DEATH MONTH DAY YEAR December 9, 1984				2b. HOUR 6:25A M			
3. SEX M		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR FEB - 18 - 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 79		7. UNDER 1 YEAR MONTHS DAYS +		7b. UNDER 24 HRS. HOURS MIN. +	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSP 9000				12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Custodian			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 802 Brunswick Rd. 21221			
14. FATHER'S NAME FIRST MIDDLE LAST SEWELL JONES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLA SMITH JONES				16. ADDRESS MD 21801			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-10-6843		17. INFORMANT ADDRESS LARRY JONES - SALISBURY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest, Metastatic Carcinoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 9, 1984 , to December 9, 1984 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 9, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE M.E. Zeitoun								DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 12-9-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.E. ZEITOUNEH								22e. ADDRESS 9000 Franklin Square Hospital 21237			
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL				23b. DATE Dec 13-1984		23c. NAME OF CEMETERY OR CREMATORY St Charles		23d. LOCATION CITY OR TOWN COUNTY STATE Chesapeake MD.			
24. FUNERAL DIRECTOR WEBSTER FUNERAL HOME				ADDRESS 1515 3rd St. Prince Georges		25a. DATE REC'D. BY REGISTRAR DEC 12 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

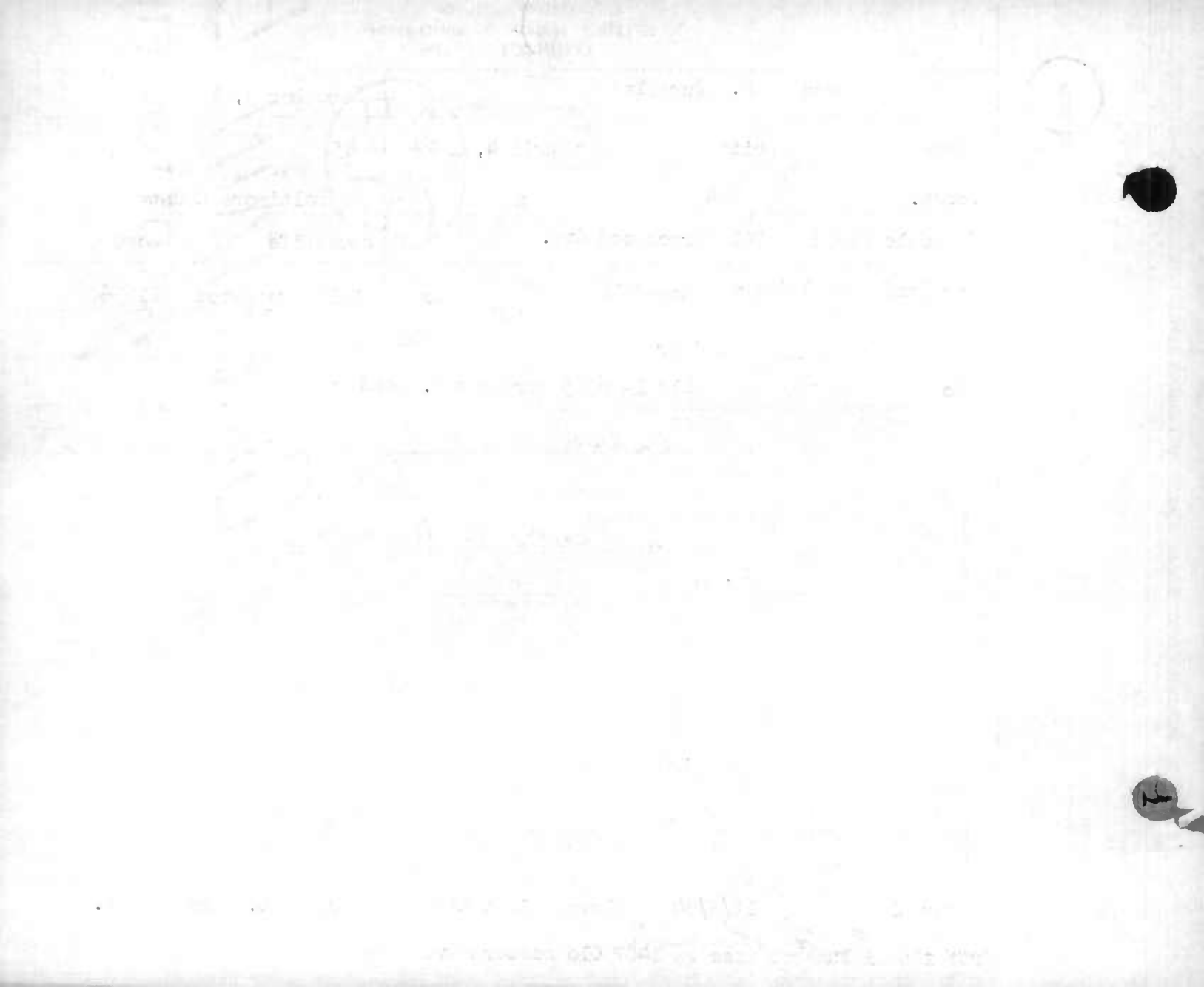
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 5 2
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Anna M. Jurella			2a DATE OF DEATH MONTH DAY YEAR December 3, 1984		2b HOUR M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 4, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 85	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Rosedale 21236	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 7418 Brookwood Ave.		12a USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland			13b CITY OR TOWN Baltimore	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d STREET ADDRESS 7418 Brookwood 21236
14 FATHER'S NAME FIRST ? MIDDLE Rodgers LAST Rodgers			15 MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 218 14 6365		17 INFORMANT ADDRESS Frances V. Keefer Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) coronary insufficiency					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH some days 1 15-20 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Organic brain syndrome					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 11/8 , 19 84 , to 12/3 , 19 84 , that (I) (we) lost saw the deceased alive on 10/5 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/4/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. BLATT, M.D.		22e ADDRESS 406 Eastern Blvd. Balto. Md 21221			
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 12/5/84	23c NAME OF CEMETERY OR CREMATORY Slovak Visitation Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Mt. Pleasant Pa.
24 FUNERAL DIRECTOR [Signature]		25a DATE REC'D. BY REGISTRAR DEC 7 1984		25b REGISTRAR'S SIGNATURE [Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as per

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 5 4
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) VASILIOS KAPETANAKOS			2a. DATE OF DEATH MONTH DAY YEAR 12-28-84			2b. HOUR 2:05 P.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 07 1937		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREECE		7b. CITIZEN OF WHAT COUNTRY? AUSTRALIA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESTAURATEUR		12b. KIND OF BUSINESS OR INDUSTRY FOOD		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 DAKIN COURT 21234	
14. FATHER'S NAME FIRST MIDDLE LAST ELIAS KAPETANAKOS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIA POLIMINAKOS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-64-4836		17. INFORMANT ADDRESS MRS. SOULLA KAPETANAKOS 9 DAKIN COURT, BALTIMORE, MD.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **MASSIVE HEMOPTYSIS & ASPIRATION**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Recurrent Coronary**

DUE TO, OR AS A CONSEQUENCE OF

Her Ang

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/28 , 19 84 , to 12/28 , 19 84 , that (I) (we) lost saw the deceased alive on 12/28 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Name]				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME Conn. A. Matthews				ADDRESS 3021 Eastern Avenue.		25a. DATE REC'D. BY REGISTRAR JAN 4 1985	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 1 5 5	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE D. KAY						2a. DATE OF DEATH MONTH DAY YEAR SUND. DEC. 23, 1984				2b. HOUR 1:50 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 7, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MILFORD MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME MAKER			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN PIKESVILLE						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, & ZIP CODE 7500 LISBURN RD. (21208)			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN DENBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 298-24-2166		17. INFORMANT ADDRESS ROBERT SEGAL 7500 LISBURN RD. (21208)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>70</u> to <u>23 DEC</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10 DEC</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Leon G. Sheer</u> DEGREE <u>M.D.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEON G. SHEER						22e. ADDRESS 6715 PARK HEIGHTS. AVE. (21215)					
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL				23b. DATE 12/24/84		23c. NAME OF CEMETERY OR CREMATORY KNOLLWOOD PARK CEM		23d. LOCATION CITY OR TOWN COUNTY STATE RIDGEWOOD, QUEENS, N.Y.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)						25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP

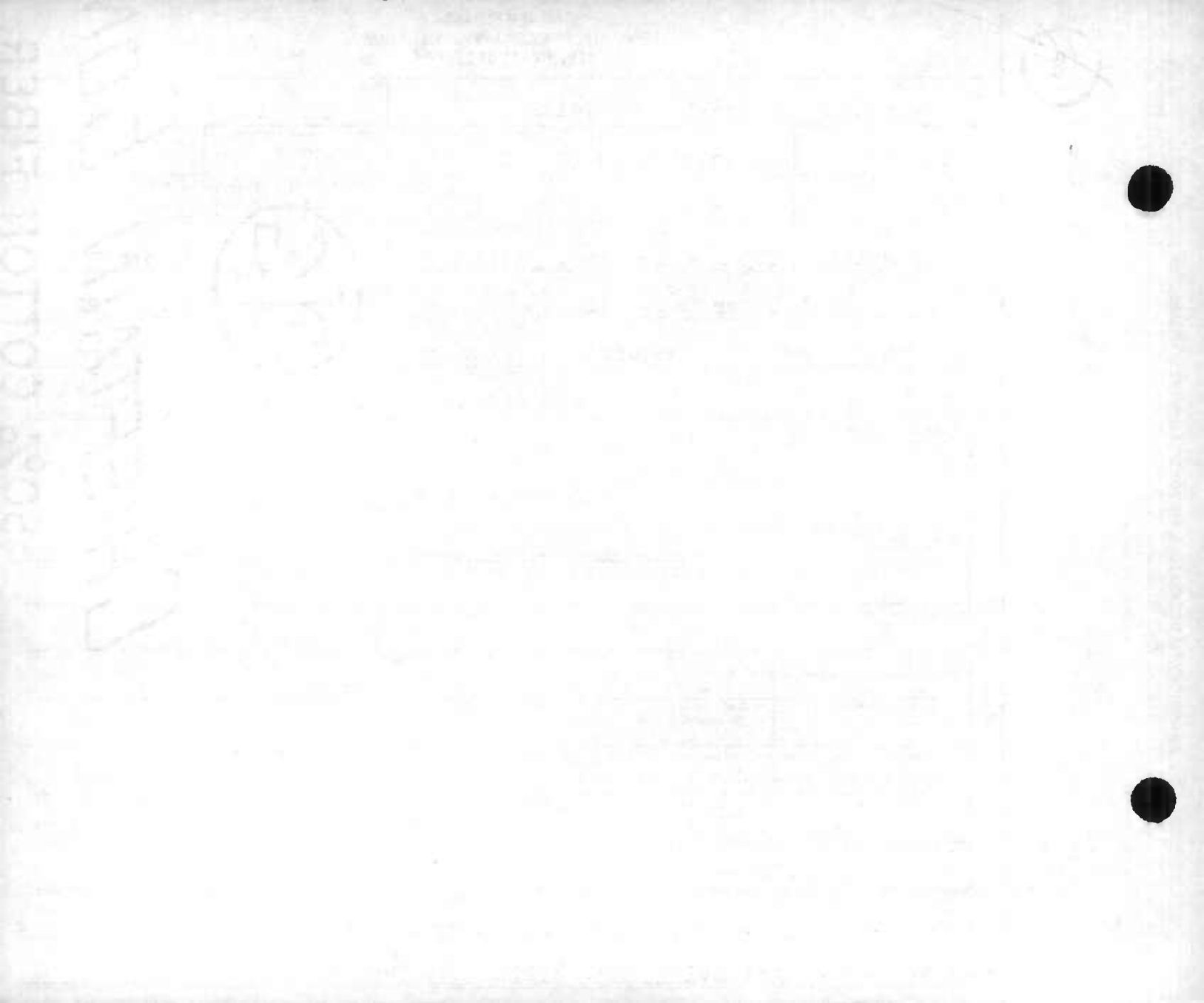


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 5 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Marie Adell Keith					2a. DATE OF DEATH MONTH DAY YEAR 12 4 84					2b. HOUR 8:04A _M			
1. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 25 02		6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 123 Newburg Ave. 21228				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 123 Newburg Ave. 21228					
14. FATHER'S NAME FIRST MIDDLE LAST Albert New DeHoff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes M. Sheppard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-0864		17. INFORMANT ADDRESS Patricia Rhine 1306 Hubner Ave. 21228									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CARCINOMATOSIS</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>													
19a. DATE OF OPERATION <u>0</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>-</u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>1812</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>-</u>									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/82</u> , 19 <u>84</u> , to <u>12-4</u> , 19 <u>84</u> that (I) (we) lost saw the deceased alive on <u>10-11</u> , 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Keith Adell</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12-5-84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>K. ARCAO</u>				22e. ADDRESS <u>3350 Belknap Ave</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>12-5-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Security Process</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Catonsville Balto. Md.</u>							
24. FUNERAL DIRECTOR NAME ADDRESS MacNabb F.H. Catonsville Md. 21228						25a. DATE REC'D. BY REGISTRAR <u>DEC 7 1984</u>		25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>					



07/84
25M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1- FOR 5/16/85 rja STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) EDWARD KELLNER						2b. DATE KNOWN OF DEATH XX MONTH DAY YEAR MATED <input type="checkbox"/> 12-31-84		2d. HOUR M 1:15A		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 3 1940		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 43 44		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
10. CITY OR TOWN OF DEATH Essex 21221			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1806 Holly Neck Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS Farming	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 500 Walnut Grove Rd. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Kellner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Thomas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 42 2838			17. INFORMANT ADDRESS Mary Kellner, Wife Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MINUTE MONTH DAY YEAR 11:49 PM 12-30-84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of a pick-up truck/fixed object impact				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) site of injury			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1805 Holly Neck Rd. Baltimore Co., Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (USE LABEL) Burial			23b. DATE 2/5/85			23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR <i>Brzezinski</i>						25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>		

DHMH - 17
(VR A15 ME (5))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 1 5 8			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Genevieve		Alberta		KELLY				December 17, 1984					7:10P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS.			
Female		Caucasian		Oct. 17, 1906		78		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Brooklyn, NY		USA				Baltimore County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Franklin Square Hospital		homemaker		--							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md.		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Balto, Md.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Albert		Hall		Hall		Ida		Hopps					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		--		051-18-3246		Jean Ehmann, dghtr, 9106 Naygall Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF Pulmonary Edema													
DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (X) (this hospital) attended the deceased from December 16, 19 84 to December 17, 19 84, that (X) (we) lost the deceased alive on December 17, 19 84, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) visit the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Julio Schwartzman				12/17/84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Julio Schwartzman, MD		9000 Franklin Square Drive, 21237											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		12/20/84		Holy Cross Cem.		BROOKLYN, COUNTY		STATE					
												N.Y.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
NAME		ADDRESS											
Schimunek Funeral Home, 9705 Belair Rd., 21236		Balto, Md.		DEC 21 1984									

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 5 9
REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gilbert F. Kennedy, Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 24 1984			2b. HOUR 9:30 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 24, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Towson				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Agent		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kennedy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Rumney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 212-07-2950		17. INFORMANT ADDRESS Margaret K. Kennedy 302 E. Joppa Rd.					
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) arterio-sclerotic Cordis Vasculae Disease years DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Cerebral Vascular Effects								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) Multiple Cerebral Vascular Effects										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from 24 September 82 to 24 December 84 , that (I) was lost saw the deceased alive on 24 December 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.										
22b. SIGNATURE Walter T. Kees					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 24 December 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter T. Kees					22e. ADDRESS Monkton Md 21111					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland					25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE John Brandon Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Edward J. Beck, Inc. Baltimore, Maryland

155 27 33

Partial

Dec. 27, 1984

Harwood

Baltimore

Harwood

Letter to Mr. Beck

11/1

Mr. Beck, Baltimore, Md.

27 Dec 84

Enclosed please find

212-07-0076, Maryland, 702 S. Jones St.

Joseph

Kennedy

Ida

Thomas

X4.

Baltimore

Townson

Robert Earl Townson

Insurance Agent, Insurance

91204

702 S. Jones St., Apt. 1011

Baltimore County

U.S.A.

82

April 17, 1983

Mr. Beck, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84-32160	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Norman C. KEYES SR.						2a. DATE OF DEATH MONTH DAY YEAR December 7 1984			2b. HOUR 12:30 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 14, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway N. H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive-MD			12b. KIND OF BUSINESS OR INDUSTRY Casualty Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 815 Stoneleigh Rd., 21210					
14. FATHER'S NAME FIRST MIDDLE LAST George Keyes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgeanna Bickner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 215 07 8681		17. INFORMANT ADDRESS Norman, C. Keyes Jr. Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Chronic Ischemic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Complete A-V Block & pacemaker APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds 10+ years 10 years										PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe degenerative osteoarthritis & bilateral knee & hips	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 14, 1964 to Dec 7, 1984 , that (I) (we) lost saw the deceased alive on Nov 23, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frederick J. Vollmer, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-8-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick J. Vollmer M.D.						22e. ADDRESS 6100 York Rd., Balto., Md. 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/10/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (CITY OR TOWN) COUNTY STATE Balto., MD			
24. FUNERAL DIRECTOR 4905 York Road, NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.						25a. DATE REC'D. BY REGISTRAR DEC 10 1984		25b. REGISTRAR'S SIGNATURE Gina Davidson-Randall			

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 1 6 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MELVIN F KIMMARLE			2a. DATE OF DEATH MONTH DAY YEAR 12 29 84		2b. HOUR 8:15AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 4, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST.		12a. USUAL OCCUPATION (IF OTHER THAN FORMER WORKING INDUSTRY) Foreman Gas & Elec Co		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 3010 Bayonne Ave 21214		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Kimmarle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Henneke				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE VERIFICATION DATES) WW 11 214-05-3284		17. INFORMANT ADDRESS Mrs Catherine Kimmarle Same As 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS						YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) LUNG CANCER, CHOLESTATIC - HEPATITIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/12 , 19 84 , to 12/29 , 19 84 , that (I) (we) lost saw the deceased alive on 12/29 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. Lobato</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. E. LOBATO				22e. ADDRESS GBMC 6701 N. CHARLES ST. TOWSON, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Rondelle</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10:00 AM

BALTIMORE COUNTY

1000 E. JEFFERSON ST.

10:00 AM

VENTRICULAR FIBRILLATION

ISCHEMIC HEART DISEASE

ATHEROSCLEROSIS

LUNG CANCER, CHOLESTASTIC - NEURITIS

10:00 AM

1000 E. JEFFERSON ST.

10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 - STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 1 6 2			
1. DECEASED NAME (TYPE OR PRINT) Anne L. KING						2a. DATE OF DEATH MONTH DAY YEAR December 19, 1984				2b. HOUR 9:40 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 24 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS 86		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Beautician			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 917 Imperial Court 21227			
14. FATHER'S NAME FIRST MIDDLE LAST Charles O. Gilliland						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Button					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-01-0277		17. INFORMANT Earle L. Lindner				ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest Coma DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia/Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from December 11, 1984 to December 19, 1984 , that (we) lost December 19, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Ciaverelle				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Ciaverelle				22e. ADDRESS 9000 Franklin Square Dr., 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment				23b. DATE 12/22/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md			
24. FUNERAL DIRECTOR NAME George J. Gonce						ADDRESS 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR DEC 21 1984		REGISTRAR'S SIGNATURE Julia Davidson	

THE UNIVERSITY OF CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 1 6 3			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Caroline Elizabeth King				2b. HOUR 12 15 84 4:10 A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 24, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH (21237) Baltimore - Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Rossville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland				13b. COUNTY Baltimore County		13c. CITY OR TOWN Baltimore 21221	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 153 Langley Road 21221			
14. FATHER'S NAME FIRST MIDDLE LAST Harmon K. Anthony				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Burnett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-03-1271		17. INFORMANT (Print) 877-1779 ADDRESS McWillard R. Amrein 1200 Fallston Road Fallston, Maryland 21047	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) - DUE TO, OR AS A CONSEQUENCE OF (c) -							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: Mild dementia; Parkinson's disease...							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 4/10/1981 to 12/15/1984, that (he/she) last saw the deceased alive on 12/15/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE M. D. TUN.		22c. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 12/15/84	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) KATHIN - M. TUN.		22f. ADDRESS Manor care Rossville, Md. 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Friends Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fallston, Harford Co., Maryland 21047	
24. FUNERAL DIRECTOR Joseph William Foster		25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Rindone			

[Faint, illegible handwritten text and markings, possibly bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]

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DHMH - 16 60M 7/84
(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 6 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Genevieve Moff Kirby			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1984		2b. HOUR 10:30 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7 N. Belle Grove Rd. 21228		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		13. STREET ADDRESS / ZIP CODE 7 N. Belle Grove Rd. 21228		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		
14. FATHER'S NAME FIRST MIDDLE LAST George Moff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (No Record) Hullar		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Mr. John P. Kirby Jr.		18. SAME AS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aplastic Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Emile Moehler</u>		DEGREE M.D.		22c. DATE SIGNED 12/26/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Emile Moehler, M.D.		22e. ADDRESS 900 S. Caton Ave. Balto., Md. 21229		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		23e. DATE REC'D BY REGISTRAR DEC 27 1984		23f. REGISTRAR'S SIGNATURE <u>Haroldson</u>		
24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, Md.						

RECEIVED
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535



2001-81-24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

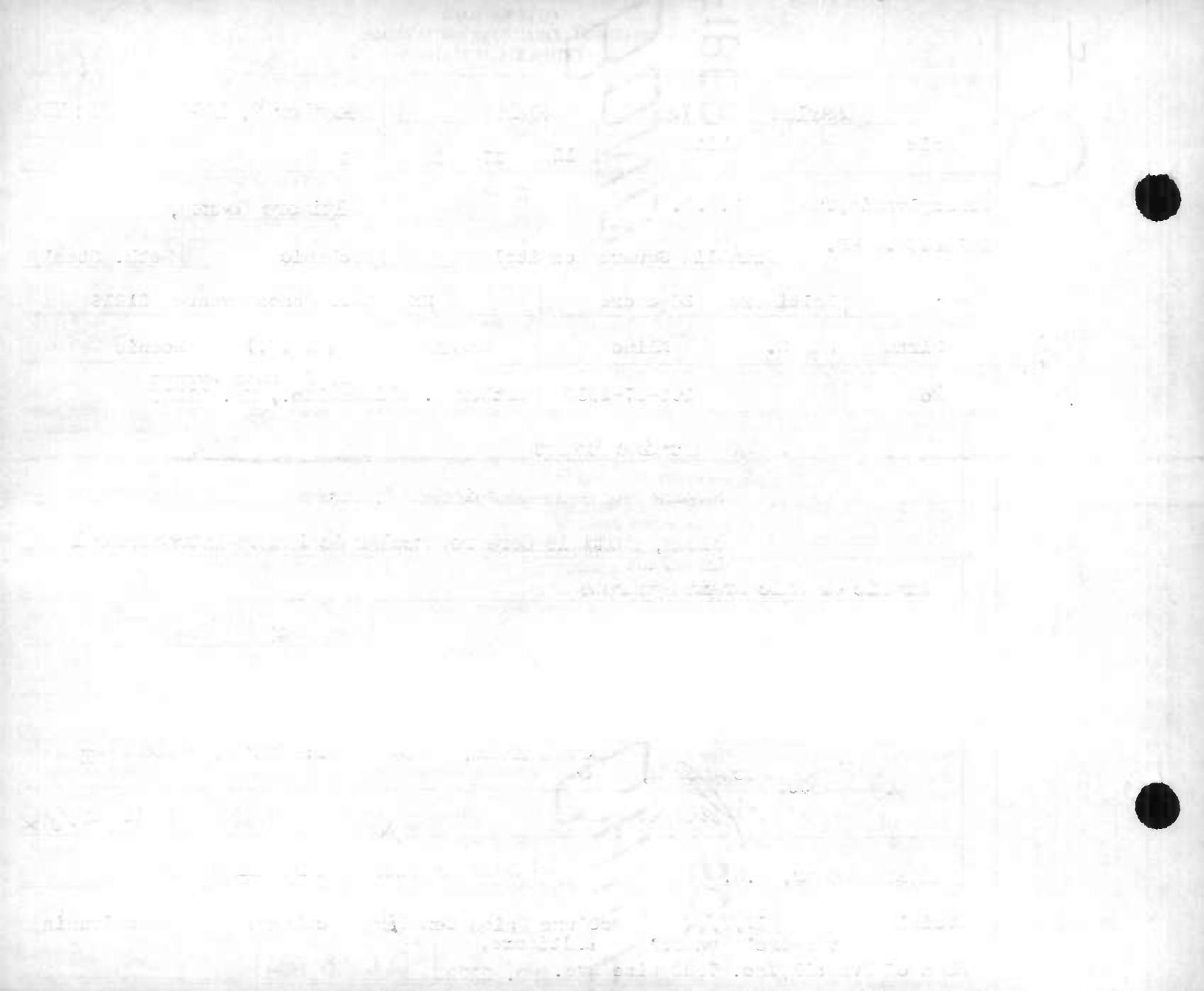
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Charles Lee KLINE					2a. DATE OF DEATH MONTH DAY YEAR December 2, 1984			2b. HOUR 12:45 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 27 02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania, USA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			
10. CITY OR TOWN OF DEATH Balto. Co., MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. CITY OR TOWN Baltimore 13c. CITY OR TOWN Edgemere					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2603 Manor Avenue 21219		
14. FATHER'S NAME FIRST MIDDLE LAST Hiram W. Kline				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Boonie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 160-07-2939		17. INFORMANT ADDRESS 2603 Manor Avenue Esther M. Kline Balto., MD. 21219			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Marasmus-Kwashiorkor Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Ileus, Multiple Cerebrovascular Accidents-Intracerebral PART 2. OTHER SIGNIFICANT CONDITIONS PRECEDING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Organic Brain Syndrome									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (X) this hospital attended the deceased from November 15, 19 84, to December 2, 19 84, that (X) (we) last saw the deceased alive on December 2, 19 84, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Naeem Gauhar					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Naeem Gauhar, M.D.					22e. ADDRESS 9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/5/84		23c. NAME OF CEMETERY OR CREMATORY McClure Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE McClure, Pennsylvania		
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. MD. 21222					25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 5 6
REG. NO.

1 - FOR STATE REGISTRAR XC 220 10 9655

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE William KNAPP, Jr.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1984		2b. HOUR 10:00A M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 28, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
						12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY WICOMICO		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 407 WOODCREST AVENUE, MD 21801	
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14. FATHER'S NAME FIRST MIDDLE LAST GEORGE William KNAPP, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Florence LEWIS		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WORLD WAR II 220 10 9655		17. INFORMANT CLINICAL RECORDS, VAMC, FORT HOWARD, MD	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LEFT PELVIC VEIN THROMBOSIS			
(c) RECENT FRACTURE OF LEFT NECK OF FEMUR			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) ORGANIC BRAIN SYNDROME			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
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21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that XX (this hospital) attended the deceased from DECEMBER 20, 1984 to DECEMBER 26, 1984 that X (we) lost saw the deceased alive on DECEMBER 26, 1984 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) XXXX saw the body after death					
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22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED 12/26/84	
		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			

22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHERUKOTH V.J. VERGHESE, M.D.		22e. ADDRESS VAMC, FORT HOWARD, MD 21052	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/1984		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Maryland	
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24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 1 6 1	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) ROGER MERCER KNILL						2a. DATE OF DEATH MONTH DAY YEAR December 2, 1984		2b. HOUR 2:52 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 0 13		7b. IF UNDER 72 HRS HOURS MIN. 0 13	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
11. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IN SUCH CITY OR TOWN GBMC 6701 N CHARLES ST				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Marina			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Woodbine				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7212 Patton Dr. 21797					
14. FATHER'S NAME FIRST MIDDLE LAST Roger S. Knill				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Mercer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1945 to '46 215-14-1998		17. INFORMANT ADDRESS Beatrice M. Knill, Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARDS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-36 HRS.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) MUCINOUS CARCINOMA-SIGMOID COLON										36 HRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/17, 1984 to 12/2, 1984 , that (I) (we) last saw the deceased alive on 12/2, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Eugene Meyer</i>				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/02/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EUGENE MEYER				22e. ADDRESS GBMC							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-5-1984		23c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		23d. LOCATION CITY OR TOWN COUNTY Carroll, Md.			
24. FUNERAL DIRECTOR Charles W. Burrier, Jr. <i>Charles Burrier</i>											

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White

Nov. 19, 1952

ALL INFORMATION

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 6 8
REG NO1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Ray O. Knotts			2a DATE OF DEATH MONTH DAY YEAR December 8, 1984			2b HOUR 9:35P.M.				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 14 1903		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10 CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riverview Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b KIND OF BUSINESS OR INDUSTRY Beth. Steel		
13a STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 2902 Dunmurry Road 21222	
14 FATHER'S NAME FIRST MIDDLE LAST Scott W. Knotts			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophrona Miner							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-0223		17 INFORMANT ADDRESS Marie Knotts Same as 13e					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Coronary Vascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Urinary Sepsis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Michael Schwartz M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12-9-84			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Schwartz M.D.					22e ADDRESS 606 Hammonds Lane Baltimore 21225					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 12/12/84		23c NAME OF CEMETERY OR CREMATORY Oak Lawn		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222					25a DATE REC'D. BY REGISTRAR DEC 11 1984		25b REGISTRAR'S SIGNATURE Davidson-Randall			

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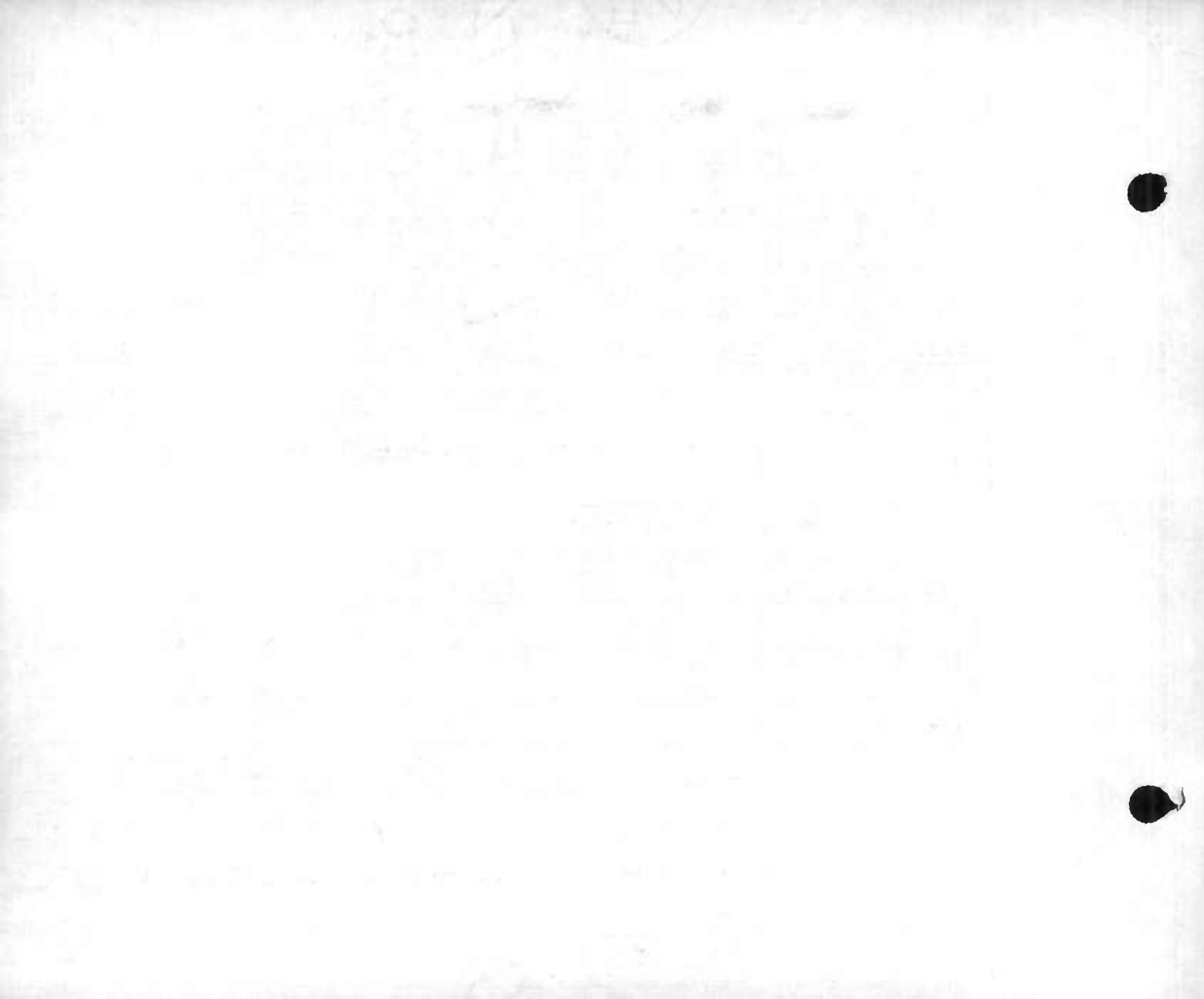
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 6 9
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK KOHLER			2a. DATE OF DEATH MONTH DAY YEAR 12 09 84			2b. HOUR 12:12			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 03 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH'S HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEELWORKER		12b. KIND OF BUSINESS OR INDUSTRY ARMCO STEEL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3834 BONVIEW AVE. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK KOHLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA HELLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-9901		17. INFORMANT ADDRESS CHARLES JAMES (BROTHER-IN-LAW) 1612 LOCHWOOD RD 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertensive Arteriosclerotic Cardiovascular disease, Renal failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>12/8</u> , 19 <u>84</u> , to <u>12/9</u> , 19 <u>84</u> , that (1) (we) lost <u>know the deceased alive on</u> <u>above (1) (we) did not view the body after death.</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>Barry Joseph</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>12/9/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY JOSEPH</u>						22e. ADDRESS <u>7600 OAKER DR. TOWSON MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/11/84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL HOME SCHIMONEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR DEC 12 1984		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	

MEDICAL CERTIFICATION

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



18

REVIEW

BALTIMORE TOWSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a necropsy performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 1 7 0 REG. NO.			
1. FOR STATE REGISTRAR XC 15480689							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CASIMIR FRANK KONDRACKI				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9, 1984		2b. HOUR 3:00 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 4, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING	
13a. STATE MARYLAND				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN MILLERSVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH KONDRACKI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MONICA ZEWBRASKI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER OF BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>NOVEMBER 26</u> , 19 <u>84</u> , to <u>DECEMBER 9</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>DECEMBER 9</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Manoranjan Singh</i>		22c. DATE SIGNED 12-9-84				22d. PHYSICIAN'S NAME (Type or Print) MANORANJAN SINGH, M.D.	
		22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Type or Print) Burial		23b. DATE 12/13/84		23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md.	
24. FUNERAL DIRECTOR NAME Raymond C. Fink Glen Burnie, Md				25a. DATE REC'D. BY REGISTRAR DEC 10 1984		25b. REGISTRAR'S SIGNATURE <i>F. Davidson Randall</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 7 1
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arthur KONSCHAK			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1984		2b. HOUR 4:20P_M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3-7-1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 60
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Field-Sales Engineer		12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5201 McFaul Road - 21206
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Korschak		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Arndt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 289-16-0223		17. INFORMANT Mrs. Dominica E. Korschak ADDRESS 5201 McFaul Rd. Balto. Md. - 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma to lung DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Metastatic brain disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that he (this hospital) attended the deceased from Dec. 20 , 19 84 , to Dec. 20 , 19 84 , that he (we) last saw the deceased alive on Dec. 20 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (do) (do not) view the body of death.					
22b. SIGNATURE Norris L. Horwitz M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norris L. Horwitz, MD		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-24-84	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206		ADDRESS 6415 Belair Rd.-21206		25a. DATE REC'D. BY REGISTRAR DEC 26 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 7 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH IRENE KOONS		2a. DATE OF DEATH MONTH DAY YEAR 12 13 84		2b. HOUR 3:00P M	
3 SEX F	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 1 17 10		6 AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N CHARLES STR	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE 11076 Greenspring Ave. 21093	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Arnold		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina Pickering		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 220 14 3776		17. INFORMANT ADDRESS Mr. Emerson W. Koons 11076 Greenspring Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE CAD DUE TO, OR AS A CONSEQUENCE OF (c)	

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/9 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12/9 84 12/13 84		21g. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/12 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22a. SIGNATURE G. Rodan	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GEORGE BEDON		22c. ADDRESS GBMC		22d. DATE SIGNED 12/13/84		22e. DEGREE MD	
22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE REC'D. BY REGISTRAR		22h. REGISTRAR'S SIGNATURE		22i. DATE SIGNED	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/17/84	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 19 1984	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 1 7 3			
1. DECEASED NAME (TYPE OR PRINT) ELLA E. KRATOCHVIL				2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 84			
3. SEX F.		4. RACE W.		5. DATE OF BIRTH MONTH 7 DAY 4 YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE TOWSON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pickergen		12b. KIND OF BUSINESS OR INDUSTRY Randy Co.	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. COUNTY Baltimore CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 813 N. Collington Ave. 21205	
14. FATHER'S NAME FIRST Michael MIDDLE Kratochvil LAST Kratochvil				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Scott LAST Scott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213206305		17. INFORMANT ADDRESS Emma F. Kratochvil 813 N. Collington Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure...							APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/29/84 to 12/13/84 , that (we) lost saw the deceased alive on 12/13/84 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHIN M. TUN.				22e. ADDRESS Manor Care Towson.			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 12-17-84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Church		23d. LOCATION (CITY OR TOWN) Baltimore Maryland	
24. FUNERAL DIRECTOR NAME [Signature] ADDRESS 1211 Chesapeake Ave.				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE [Signature]	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 1 7 4

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Pearl Kreutzer			2a. DATE OF DEATH MONTH DAY YEAR Dec. 23, 1984			2b. HOUR 5 55 ^{PM}			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 6, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summitt Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5662 Woodmont Ave. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Walter L. Kendall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma A. Glenn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Theodore J. Potthast, Jr. 608 Baltimore Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pneumonitis and**

DUE TO, OR AS A CONSEQUENCE OF:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Congestive Failure heart**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Recent small stroke severe Parkinsonism

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 28 Aug. 1976 to 23 Dec. 1984 that (I) (we) lost saw the deceased alive on 22 Dec. 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James E. Rowe				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. E. ROWE				22e. ADDRESS Summitt Nursing Home			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Madeline Kroner		2a. DATE OF DEATH MONTH DAY YEAR 12/18/84		2b. HOUR 11 P M		REG. NO. 3 2 1 7 5			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 26 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK, FOR WHAT, OR WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1734 Langley Rd. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST John Horlamus				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan McCartin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 12 7685		17. INFORMANT ADDRESS Henry J. Kroner, Son 5911 Plumer Ave. Baltimore, Md. 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Cancer									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 84 , to 12/18 , 19 84 , that (I) (we) last saw the deceased alive on 12/18 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kendall R. Faulkner MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall R. Faulkner				22e. ADDRESS Dulaney Valley Rd Towson					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/21/84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL HOME Brudzinski Funeral Home PA 1407 Old Eastern Ave						25a. DATE REC'D. BY REGISTRAR DEC 20 1984		25b. REGISTRAR'S SIGNATURE Julia T. Anderson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 7 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM V KROUPA					2a. DATE OF DEATH MONTH DAY YEAR DEC. 1, 1984			2b. HOUR 11:30am			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 30 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY County MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8005 GOUGH STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY ANCHOR MOTOR FREIGHT			
13a. STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8005 GOUGH ST. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM KROUPA SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PHYLLIS UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-01-8437		17. INFORMANT ADDRESS ETHEL KROUPA (WIFE) SAME ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Spontaneous DUE TO, OR AS A CONSEQUENCE OF (b) Dissecting Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ACLD - Acute pancreatitis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 83 , to 12/1 , 19 84 , that (I) (we) last saw the deceased alive on 11/29 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Joseph R. Liberto, MD (IF PHYSICIAN'S NAME (TYPE OR PRINT))					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/3/84			
22d. ADDRESS DR. JOSEPH R. LIBERTO					22e. ADDRESS 3508 Bank St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/4/84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.					
24. FUNERAL DIRECTOR NAME ADDRESS SCHTMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR DEC 4 1984		25b. REGISTRAR'S SIGNATURE Richardson-Randall			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 1 7 7

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mrs. Margaret Kutlik			2a. DATE OF DEATH MONTH DAY YEAR December 14 1984			2b. HOUR 4:18 a				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 10 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Pikesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shirt Manufacturer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 100 Waldron Avenue 21208	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bullinger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Helwig			16. ADDRESS Mrs. Margaret Podczaski 21208 100 Waldron Avenue Pikesville Maryland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-20-8781		17. INFORMANT Mrs. Margaret Podczaski				18. ADDRESS 21208 100 Waldron Avenue Pikesville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 8 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Organic brain disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Aug 12 19 72 to Dec 14 19 84 , that (I) (we) last saw the deceased alive on Dec 14 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Manuel Levin			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D.			22e. ADDRESS 6101 PARK HILLS AVE BALTO MD 21215							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-17-84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland			
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133						25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE Richardson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 7 8
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH (NMI) LAIKEN			2a. DATE OF DEATH MONTH DEC DAY 1 YEAR 84			2b. HOUR 3:45 AM M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 11 DAY 13 YEAR 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Broker		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE DELAWARE				13b. COUNTY NEW CASTLE		13c. CITY OR TOWN WILMINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Joseph MIDDLE LAST Laiker				15. MOTHER'S MAIDEN NAME FIRST Pearl MIDDLE LAST Brill				16. STREET ADDRESS / ZIP CODE 4006 BYRON RD 19802	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 796-01-6337		17. INFORMANT ADDRESS Mrs. Evelyn Laiker Wilmington, Delaware			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 YRS	
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS								20 YRS	
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES AND HYPERTENSION									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ACUTE + CHRONIC RENAL FAILURE ACUTE PULMONARY EDEMA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Nov 10 19 84 to DEC 1 19 84 , that (1) (we) lost saw the deceased alive on DEC 1 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Nathan Rosenblum						DEGREE MD		22c. DATE SIGNED DEC 1 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATHAN ROSENBLUM, MD						22e. ADDRESS 7600 OSLER DRIVE TOWSON, MD 21204			
23a. BURIAL, CREMATION, REMOVAL (ENTRY) Burial			23b. DATE DEC 3, 1984		23c. NAME OF CEMETERY OR CREMATORY Har Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Collinsdale, Delaware, Pennsylvania		
24. FUNERAL DIRECTOR NAME Charles Kravitz						25a. DATE REC'D. BY REGISTRAR DEC 07 1984			
ADDRESS 519 Philadelphia Pike, Wilm. De						25b. REGISTRAR'S SIGNATURE Julia Burdick			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in cases.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 1 7 9	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH E. LAIRD						2a. DATE OF DEATH MONTH DAY YEAR 12 04 '84		2b. HOUR 11:15 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 21, 1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8015 York Rd. Apt. B-4 21204			
14. FATHER'S NAME FIRST MIDDLE LAST John Wirth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dena Geumann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-0166		17. INFORMANT ADDRESS Lunda W. Laird 8015 York Road 21204							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CANCER BREAST, METASTASIS TO BONE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 84 , to 12/4 , 19 84 , that (I) (we) last saw the deceased alive on 12/4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ralph W. Fawcett DEGREE								22c. DATE SIGNED 12/4/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH W. FAWCETT, M.D.						22e. ADDRESS GBMC - 6701 N. CHARLES STREET					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE <i>W. J. Anderson</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

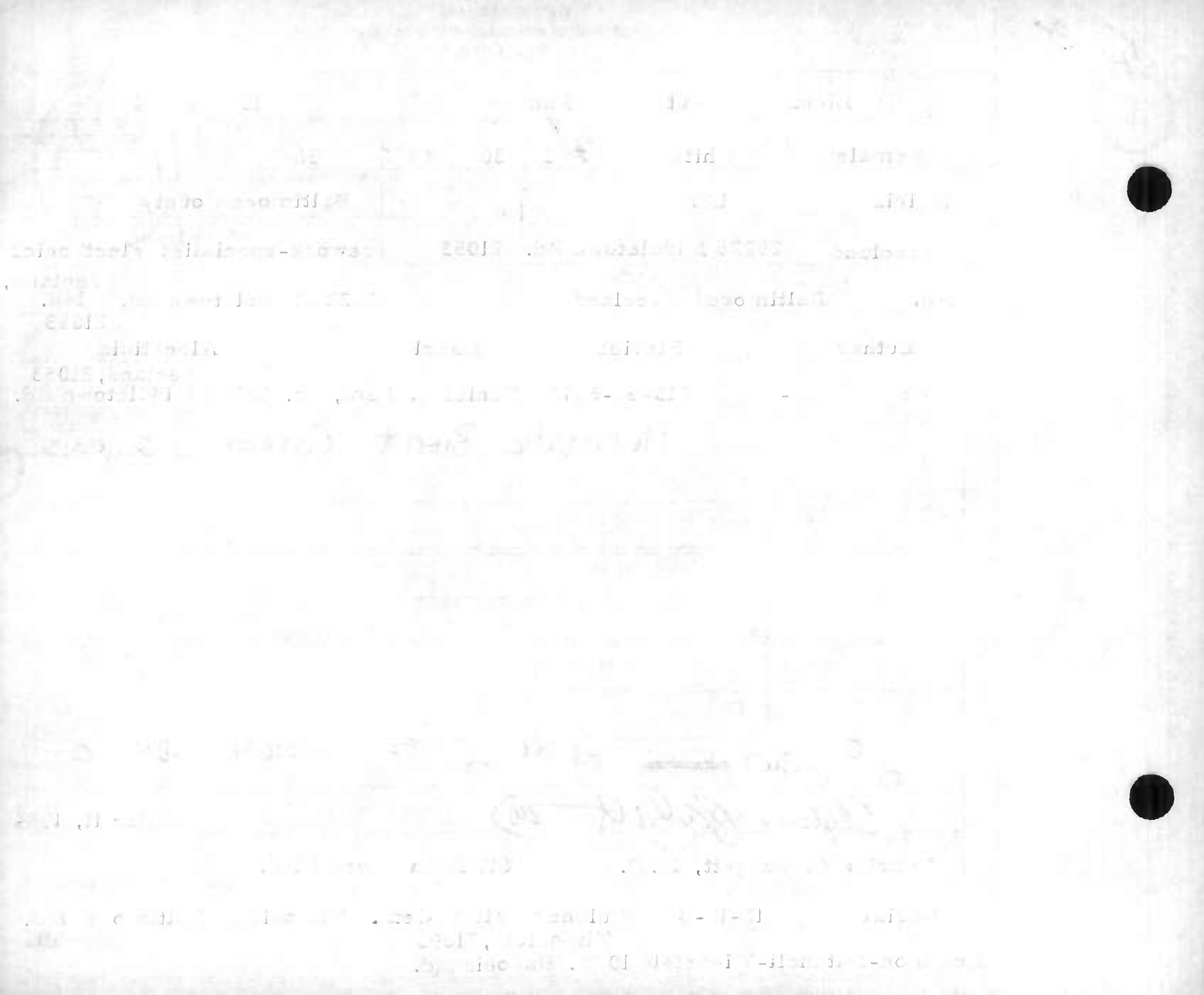
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(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR		REG. NO. 32180							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	
Linna Ruth Lam								MONTH DAY YEAR	
								12 9 84	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		MONTH DAY YEAR		36 YRS		M	
3 30 48									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		USA				Baltimore County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Freeland		20225 Middletown Rd. 21053				rework-specialist		electronics	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Baltimore		Freeland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20225 Middletown Rd. Md.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
Luther		Blevins		No -					
				16b. SOCIAL SECURITY NO. 213-52-6570					
				17. INFORMANT ADDRESS Daniel R. Lam, Sr. 20225 Middletown Rd. Freeland, 21053					
				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Cancer					
				DUE TO, OR AS A CONSEQUENCE OF (b) 2 years					
				DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 84 Dec 82, to Dec 9, 19 84, that (I) (we) lost saw the deceased alive on Dec 7, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
Charles Padgett		Dec 11, 1984		Charles A. Padgett, M. D.					
				22e. ADDRESS					
				2619 Loch Raven Blvd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		12-12-84		Dulaney Valley Cem.		Timonium, Baltimore Md.			
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lemmon-Mitchell-Wiedefeld		DEC 11 1984							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 2 1 8 1 REG. NO.		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
FIRST MIDDLE LAST HATTIE LANFORD		12 13 84 0818AM							
3. SEX F female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 21, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6409 Gilmore Ave. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Bragg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Mildred Bishop					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-12-0080D		17. INFORMANT Mrs. Marguerite Hanger 24401 228 Old Greenville Road Staunton, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ELECTROMECHANICAL DISSOCIATION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>PERMANENT PACEMAKER</u>									
19a. DATE OF OPERATION 12/8/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED C.H.B.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hafeez A. Syed				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEEZ A SYED MD				22e. ADDRESS BALTIMORE COUNTY GEN HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/84		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY Woodlawn Baltimore MD.			
24. FUNERAL DIRECTOR NAME 8728 Liberty Rd. Randallstown, MD 21133 Loring Byers Funeral Directors, Inc.				25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Joseph		E.		Laumann				12		24		84					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.							
Male		White		MONTH 5 DAY 31 YEAR 13		71		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA				Baltimore County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Dundalk		East Point Nursing Home		Retired													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Maryland		Baltimore		Dundalk		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8065 Wallace Rd.		21222							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Ira		Martha															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		217-03-0627		Elizabeth Laumann		8065 Wallace Rd.		21222									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		DUE TO, OR AS A CONSEQUENCE OF		(b) <u>Post pneumonia; Cardiac arrhythmia; CVA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		<u>Immediate</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		(c) <u>Arteriosclerosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>84</u> , to <u>12/24</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Joseph J. Cameron</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/26/84</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Joseph J. Cameron		1012 North 11th Rd Balto, Md 21204															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		12/29/84		Meadowridge Mem. Pk.		Baltimore Maryland											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
A. Alan Seitz, Jr. 3818 Roland Ave. 21211		DEC 28 1984		John Davidson													



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

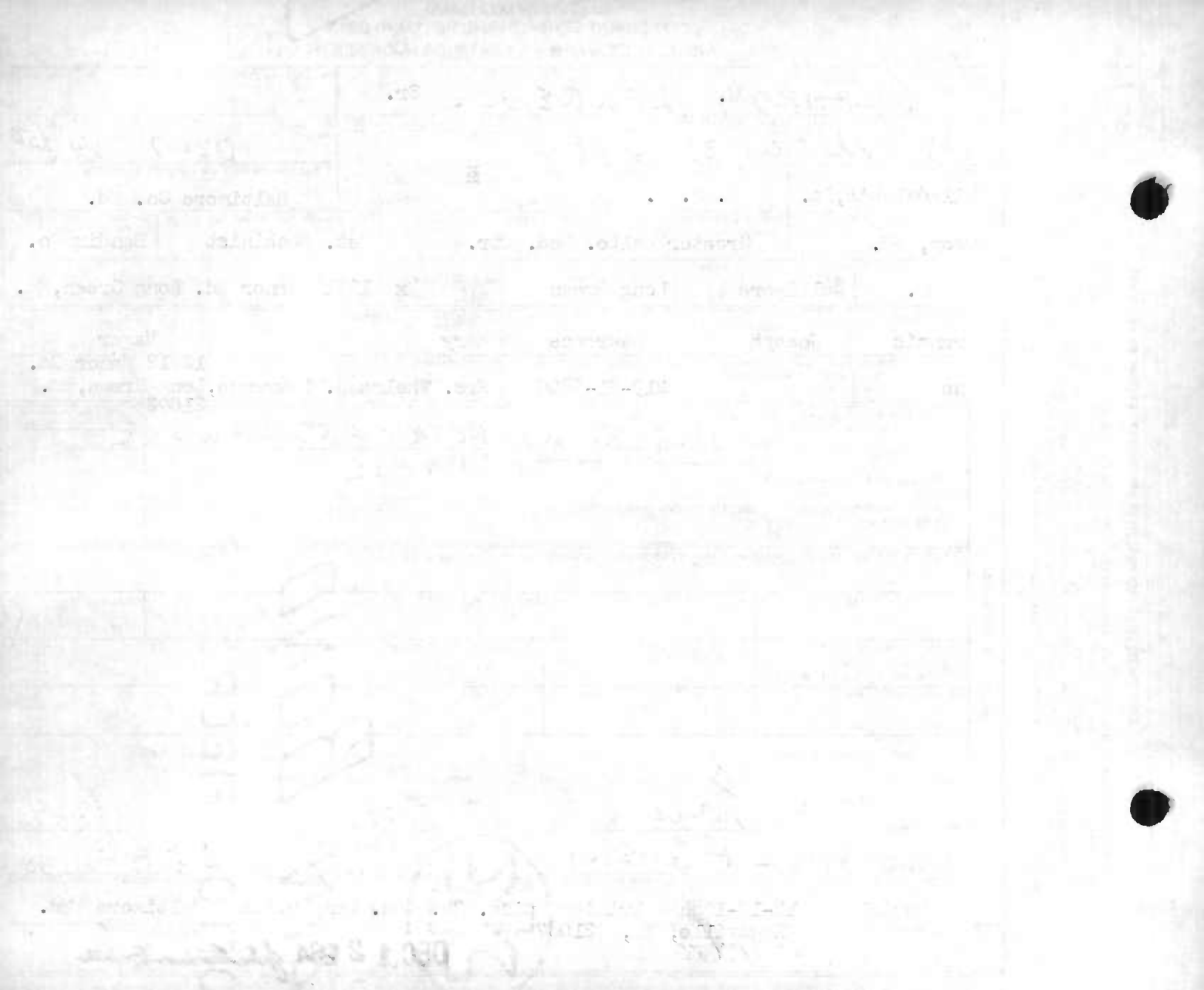
BP

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 3 2 8 3

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RICHARD W. LAWRENCE Sr.			2b. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 <input type="checkbox"/> HOUR		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR OCT 25 1916 68 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD DEC 7 1984	2d. HOUR 458
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia, Pa.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Towson, Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Balto. Med. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Machinist	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Joseph Lawrence		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hager		17. INFORMANT ADDRESS 12712 Manor Rd. Long Green, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-01-5800		17. INFORMANT ADDRESS Mrs. Thelma S. Lawrence, Long Green, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DUE TO, OR AS A CONSEQUENCE OF DISEASE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Paul K. Guerin		M.D. DEPUTY		DATE SIGNED 12/8/84	
EXAMINER'S NAME (TYPE OR PRINT) PAUL K GUERIN		ADDRESS 1311 WESTERN RD COCKEYSVILLE MD 21030			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-10-1984		23c. NAME OF CEMETERY OR CREMATORY Trinity Episc. Ch. Cem.	
24. FUNERAL DIRECTOR NAME Loessahn FH		ADDRESS Kingsville, Md. 21087		25a. DATE REC'D. BY REGISTRAR DEC 12 1984	
				25b. REGISTRAR'S SIGNATURE [Signature]	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 1 8 4 REC. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eva Myrtle Leonard						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 19 84		2b. HOUR 0010 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 24 1896		6. AGE (IN YEARS) LAST BIRTHDAY 88 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2515 Menser Avenue 21219				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2515 Menser Avenue 21219			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Moore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Fisher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 228.03.1845D		17. INFORMANT ADDRESS Phyllis A. Bean (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic generalized ischemic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE J. C. Coston				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED 12/19/84	
EXAMINER'S NAME (TYPE OR PRINT) J. C. Coston				ADDRESS 2112 Dundalk Ave., Balto., Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/21/1984		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD					
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc.				ADDRESS Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR DEC 21 1984		25b. REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 1 8 5	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Judith LEONARD			2a. DATE OF DEATH MONTH DAY YEAR December 4, 1984		2b. HOUR 2:00a M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 03 17 12		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN ROSEDALE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1825 WEYBURN RD. 21237
14. FATHER'S NAME FIRST MIDDLE LAST JOHN POPKO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN -----			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 054032474		17. INFORMANT ADDRESS JOHN LEONARD 1825 WEYBURN RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Granule Cytopenia DUE TO, OR AS A CONSEQUENCE OF Adult onset diabetes mellitus, Hypertension (b) Congestive Heart Failure, Chronic renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (H) (this hospital) attended the deceased from December 3, 1984 , to December 4, 1984 , that (H) (we) last saw the deceased alive on December 4, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Fernando J. Acle, MD				22c. DATE SIGNED 12/04/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fernando J. Acle, M.D.				22e. ADDRESS 9000 Franklin Sq. Dr., 21237	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/04/84		23c. NAME OF CEMETERY OR CREMATORY GRADENS OF FAITH	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALT. MD.					
24. FUNERAL DIRECTOR NAME Jellyhal ADDRESS 1211 Chesaw Ave				25a. DATE REC'D. BY REGISTRAR DEC 5 1984	
				25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1-8 6
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA Regina LEONHARDT		2a. DATE OF DEATH MONTH DAY YEAR 12 27 84		2b. HOUR 8:52P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10 10 95		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, MD XRAY County MD	
10. CITY OR TOWN OF DEATH Baltimore Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Nursing Home		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Housework	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ignatz Kleinheitz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-12-2466	
17. INFORMANT ADDRESS Albert E. Leonhardt 541 Larkfield Rd. 21222		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 YEARS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>							

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> 19 <u>81</u> , to <u>12/27</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>B.C. Veneracion Jr.</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.C. VENERACION JR.		22e. ADDRESS 3401 Dundalk Ave. & Hb Ave.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				ADDRESS 6224 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR DEC 28 1984	
				25b. REGISTRAR'S SIGNATURE [Signature]			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 8 7
REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH		21. HOUR	
SAUL LERNER		12 17 84		2 40	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
MALE	WHITE	DEC. 17, 1905	79 YRS.	MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
RUSSIA	U.S.A.		BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
RANDALLSTOWN	BALTO. CO. GEN. HOSP.		MERCHANT		RETAIL
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	#21215 6972 MILBROOK PARK DR., APT. 2B	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
AARON LERNER	JESSE RUBENSTEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMATION MR. BERYL LERNER			
NO	213-34-0341	3710 PINELEA RD. #21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Sepsicemia</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-17-84 to 12-17-84, that (I) (we) last saw the deceased alive on 12-17-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		DEGREE		12-17-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
RAYA DOURG G RD		Balt County Gen Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. COUNTY
BURIAL		12-18-84	KNESSETH ISRAEL ANSHE KOLK	BALTO.	MD
24. FUNERAL DIRECTOR			25. DATE REC'D BY REGISTRAR		
SOL LEVINSON & BROS., INC.			DEC 19 1984		
6010 REISTERSTOWN RD., BALTO., MD 21215			REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 1 8 8

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virgie I. LETHCOE			2a DATE OF DEATH MONTH DAY YEAR December 5, 1984		2b HOUR 6:25P M
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 5/12/28	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10 CITY OR TOWN OF DEATH ROSSVILLE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE	12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b CITY OR TOWN BALTO	13c CITY OR TOWN MIDDLE RIVER	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 21220 210 GLIDER DR.
14 FATHER'S NAME FIRST MIDDLE LAST EDGAR HAMM			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 22934 0821	17 INFORMANT ADDRESS HOWARD LETHCOE ABOVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Ventricular Rupture, Acute Anterior Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that M. (this hospital) attended the deceased from November 29, 1984 to December 5, 1984 that we last saw the deceased alive on December 5, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (did) not view the body after death.					
22b SIGNATURE M. Delahunt		DEGREE M.D.		22c DATE SIGNED 12/5	
22d PHYSICIAN'S NAME (TYPE OR PRINT) M. Delahunt, MD		22e ADDRESS 9000 Franklin Square Dr., 21237			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 12/10/84	23c NAME OF CEMETERY OR CREMATORY GARDENS OF SAATH	23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD		
24 FUNERAL DIRECTOR NAME J.G. CONNELLY			ADDRESS 300 MALE		25a DATE REC'D. BY REGISTRAR DEC 12 1984
			25b REGISTRAR'S SIGNATURE Julia Davidson-Rendall		

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with 772 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, signs any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 8 9
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>(Matilda) Matilda K. Little</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12/28/84</i>			2b. HOUR MIN. <i>11:15A</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 28 98</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i>		7. UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Valley View Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ball Shoe Factory</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		
13a. STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>601 Wyanoak Ave.-21218</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John them</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Mohr</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>212-28-2677</i>		17. INFORMANT ADDRESS <i>Mr. Vincent C. Little Fallston, Md.-21047</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dehydration</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Organic Brain Ed</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <i>12/28/84</i> to <i>12/28/84</i> , that (I) (we) lost saw the deceased alive on <i>12/28/84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.										
22b. SIGNATURE <i>Vu N GUYEN</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/28/84</i>		
22d. PHYSICIAN'S NAME (OR PRINT) <i>VUONG VU N GUYEN</i>				22e. ADDRESS <i>6331 Belair Rd Balto Md 21206</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-31-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Zion Luth Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>				
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc. -6415 Belair Rd.-212060</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 2 1985</i>		25b. REGISTRAR'S SIGNATURE <i>W. W. Wilson-Randall</i>				

BP

8-10-67

1973 August 19
1973 August 20

15-25-77 N. Vincent

10. 11. 1941

12-1-41

John C. Walker Inc., 2117 Belmont St., St. Louis 8, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 9 0
REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST FRANCES LEVINSON		2a. DATE OF DEATH MONTH DAY YEAR December 1 1984		2b. HOUR 3:30 p.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13 1895	
6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		8. IF UNDER 1 YEAR MONTHS DAYS 89	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		10. CITY OR TOWN OF DEATH Sudbrook Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7408 Campfield Rd.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 7408 Campfield Rd. 21208	
13b. STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Freedman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Abrams		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 214-74-3487		17. INFORMANT Rhea Satren		ADDRESS 7408 Campfield Rd. 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Osteoarthritis Spine & pelvis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1950	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 1950 to 12/1 19 84 , that (I) (we) lost saw the deceased alive on 11/15 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Edward S. Hallins MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 12/2/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD S. HALLINS MD		22e. ADDRESS 6000 PARK HEIGHTS AV 21215	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/3/84		23c. NAME OF CEMETERY OR CREMATORY Oheb Shalom. O'Donnell	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		24. FUNERAL DIRECTOR NAME ADDRESS Hebrew Memorial F.H. 1100 Reisterstown Rd. Pikesville, MD		25a. DATE REC'D. BY REGISTRAR DEC 3 1984	
25b. REGISTRAR'S SIGNATURE Jane Anderson					

BP _____



RECEIVED
JAN 10 1871
NEW YORK

7

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR FOUR YEARS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (1))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 1 9 1

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alma Leigh Lewis		2a. DATE KNOWN OF DEATH ESTIMATED 12/28 19 84		2b. HOUR 10^{PM}
3. SEX Female	4. RACE White	5. DATE OF BIRTH June 16 1919	6. AGE (IN YEARS) 65	7. DATE PRONOUNCED DEAD 12/28/84 19 11^{PM}
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Natural Bridge, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 202 Apt 2B Middleway Rd.		12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Housewife
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS 202 2B Middleway Rd. 21220
14. FATHER'S NAME FIRST MIDDLE LAST Robert Nuckles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mayo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 225 26 0835		17. INFORMANT ADDRESS Mason W. Lewis, Husband Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Theo C. Patterson		TITLE (SPECIFY) M.D.		DATE SIGNED 12/28/84
EXAMINER'S NAME (TYPE OR PRINT) THEO.C. PATTERSON		ADDRESS 3427 Dundalk Ave 21222		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/2/85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co., Md.
24. FUNERAL DIRECTOR Wladzinski Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

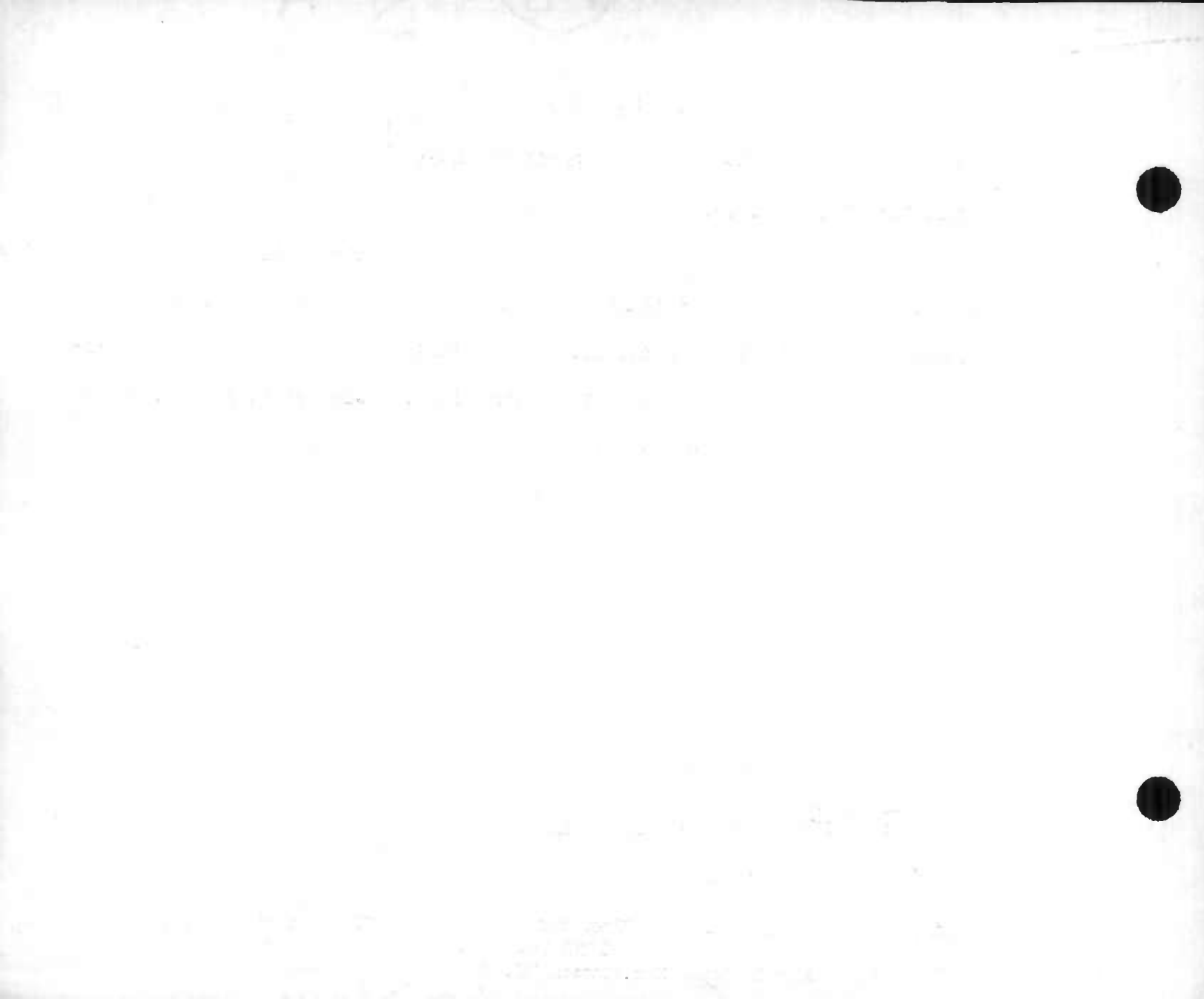
IMPORTANT: If item 21 is marked on item 18 above any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 1 9 2

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10 ⁰⁰ A M	
Major Bennett Lewis		Dec. 30 1984			
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	# UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	93	# UNDER 24 HRS	
		April 27, 1891			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
North Carolina	U.S.A.		Balto. County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Towson	Stella Maris		Retired-Milkman		Western Md. Dairy
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	807 Lenton Ave. 21212
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Starkey Major Lewis, Sr.		Smithie McFields			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-10-3878		Starkie M. Lewis - 19 Warwick Dr. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Acute Myocardial Infarction					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Arteriosclerotic Cardio Vascular Disease					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR			
		P.M.			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 19 83, to Dec. 30 19 84, that (I) (we) last saw the deceased alive on December 20 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Kendall R. Faulkner MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Kendall R. Faulkner		Stella Maris Hospice			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	1-3-85	Glen Haven		Glen Burnie, A.A., Maryland	
24. FUNERAL DIRECTOR		1050 York Rd.		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS				25b. REGISTRAR'S SIGNATURE	
Ruck Towson Funeral Home, Inc. Towson, Md. 21204		JAN 2 1985		Julia Davidson-Randall	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 1 9 3
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>alice R. Light</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12/16/84</i>		2b. HOUR <i>10:17 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 6 87</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. County.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Manor Care Towson</i>		12a. USUAL OCCUPATION (IF NOT OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Balt.</i>		13c. CITY OR TOWN <i>Balt.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Kaufman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine -</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-14-0375</i>		17. INFORMANT ADDRESS <i>Mr. Henry B. Light Same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intra cerebral glioma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>(Brain Tumor)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>12/6/84</i> to <i>12/16/84</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>12/16/84</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death.							
22b. SIGNATURE <i>Wm. Jones</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/16/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KHIN -M. TUN</i>		22e. ADDRESS <i>Manor Care Towson Md 21204</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 20, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Baltimore, Maryland</i>				25. DATE REC'D. BY REGISTRAR <i>DEC 19 1984</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

No. 1		No. 2		No. 3		No. 4		No. 5		No. 6		No. 7		No. 8		No. 9		No. 10		No. 11		No. 12		No. 13		No. 14		No. 15		No. 16		No. 17		No. 18		No. 19		No. 20		No. 21		No. 22		No. 23		No. 24		No. 25		No. 26		No. 27		No. 28		No. 29		No. 30		No. 31		No. 32		No. 33		No. 34		No. 35		No. 36		No. 37		No. 38		No. 39		No. 40		No. 41		No. 42		No. 43		No. 44		No. 45		No. 46		No. 47		No. 48		No. 49		No. 50		No. 51		No. 52		No. 53		No. 54		No. 55		No. 56		No. 57		No. 58		No. 59		No. 60		No. 61		No. 62		No. 63		No. 64		No. 65		No. 66		No. 67		No. 68		No. 69		No. 70		No. 71		No. 72		No. 73		No. 74		No. 75		No. 76		No. 77		No. 78		No. 79		No. 80		No. 81		No. 82		No. 83		No. 84		No. 85		No. 86		No. 87		No. 88		No. 89		No. 90		No. 91		No. 92		No. 93		No. 94		No. 95		No. 96		No. 97		No. 98		No. 99		No. 100		No. 101		No. 102		No. 103		No. 104		No. 105		No. 106		No. 107		No. 108		No. 109		No. 110		No. 111		No. 112		No. 113		No. 114		No. 115		No. 116		No. 117		No. 118		No. 119		No. 120		No. 121		No. 122		No. 123		No. 124		No. 125		No. 126		No. 127		No. 128		No. 129		No. 130		No. 131		No. 132		No. 133		No. 134		No. 135		No. 136		No. 137		No. 138		No. 139		No. 140		No. 141		No. 142		No. 143		No. 144		No. 145		No. 146		No. 147		No. 148		No. 149		No. 150		No. 151		No. 152		No. 153		No. 154		No. 155		No. 156		No. 157		No. 158		No. 159		No. 160		No. 161		No. 162		No. 163		No. 164		No. 165		No. 166		No. 167		No. 168		No. 169		No. 170		No. 171		No. 172		No. 173		No. 174		No. 175		No. 176		No. 177		No. 178		No. 179		No. 180		No. 181		No. 182		No. 183		No. 184		No. 185		No. 186		No. 187		No. 188		No. 189		No. 190		No. 191		No. 192		No. 193		No. 194		No. 195		No. 196		No. 197		No. 198		No. 199		No. 200		No. 201		No. 202		No. 203		No. 204		No. 205		No. 206		No. 207		No. 208		No. 209		No. 210		No. 211		No. 212		No. 213		No. 214		No. 215		No. 216		No. 217		No. 218		No. 219		No. 220		No. 221		No. 222		No. 223		No. 224		No. 225		No. 226		No. 227		No. 228		No. 229		No. 230		No. 231		No. 232		No. 233		No. 234		No. 235		No. 236		No. 237		No. 238		No. 239		No. 240		No. 241		No. 242		No. 243		No. 244		No. 245		No. 246		No. 247		No. 248		No. 249		No. 250		No. 251		No. 252		No. 253		No. 254		No. 255		No. 256		No. 257		No. 258		No. 259		No. 260		No. 261		No. 262		No. 263		No. 264		No. 265		No. 266		No. 267		No. 268		No. 269		No. 270		No. 271		No. 272		No. 273		No. 274		No. 275		No. 276		No. 277		No. 278		No. 279		No. 280		No. 281		No. 282		No. 283		No. 284		No. 285		No. 286		No. 287		No. 288		No. 289		No. 290		No. 291		No. 292		No. 293		No. 294		No. 295		No. 296		No. 297		No. 298		No. 299		No. 300		No. 301		No. 302		No. 303		No. 304		No. 305		No. 306		No. 307		No. 308		No. 309		No. 310		No. 311		No. 312		No. 313		No. 314		No. 315		No. 316		No. 317		No. 318		No. 319		No. 320		No. 321		No. 322		No. 323		No. 324		No. 325		No. 326		No. 327		No. 328		No. 329		No. 330		No. 331		No. 332		No. 333		No. 334		No. 335		No. 336		No. 337		No. 338		No. 339		No. 340		No. 341		No. 342		No. 343		No. 344		No. 345		No. 346		No. 347		No. 348		No. 349		No. 350		No. 351		No. 352		No. 353		No. 354		No. 355		No. 356		No. 357		No. 358		No. 359		No. 360		No. 361		No. 362		No. 363		No. 364		No. 365		No. 366		No. 367		No. 368		No. 369		No. 370		No. 371		No. 372		No. 373		No. 374		No. 375		No. 376		No. 377		No. 378		No. 379		No. 380		No. 381		No. 382		No. 383		No. 384		No. 385		No. 386		No. 387		No. 388		No. 389		No. 390		No. 391		No. 392		No. 393		No. 394		No. 395		No. 396		No. 397		No. 398		No. 399		No. 400		No. 401		No. 402		No. 403		No. 404		No. 405		No. 406		No. 407		No. 408		No. 409		No. 410		No. 411		No. 412		No. 413		No. 414		No. 415		No. 416		No. 417		No. 418		No. 419		No. 420		No. 421		No. 422		No. 423		No. 424		No. 425		No. 426		No. 427		No. 428	
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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 9 4
REG. NO.

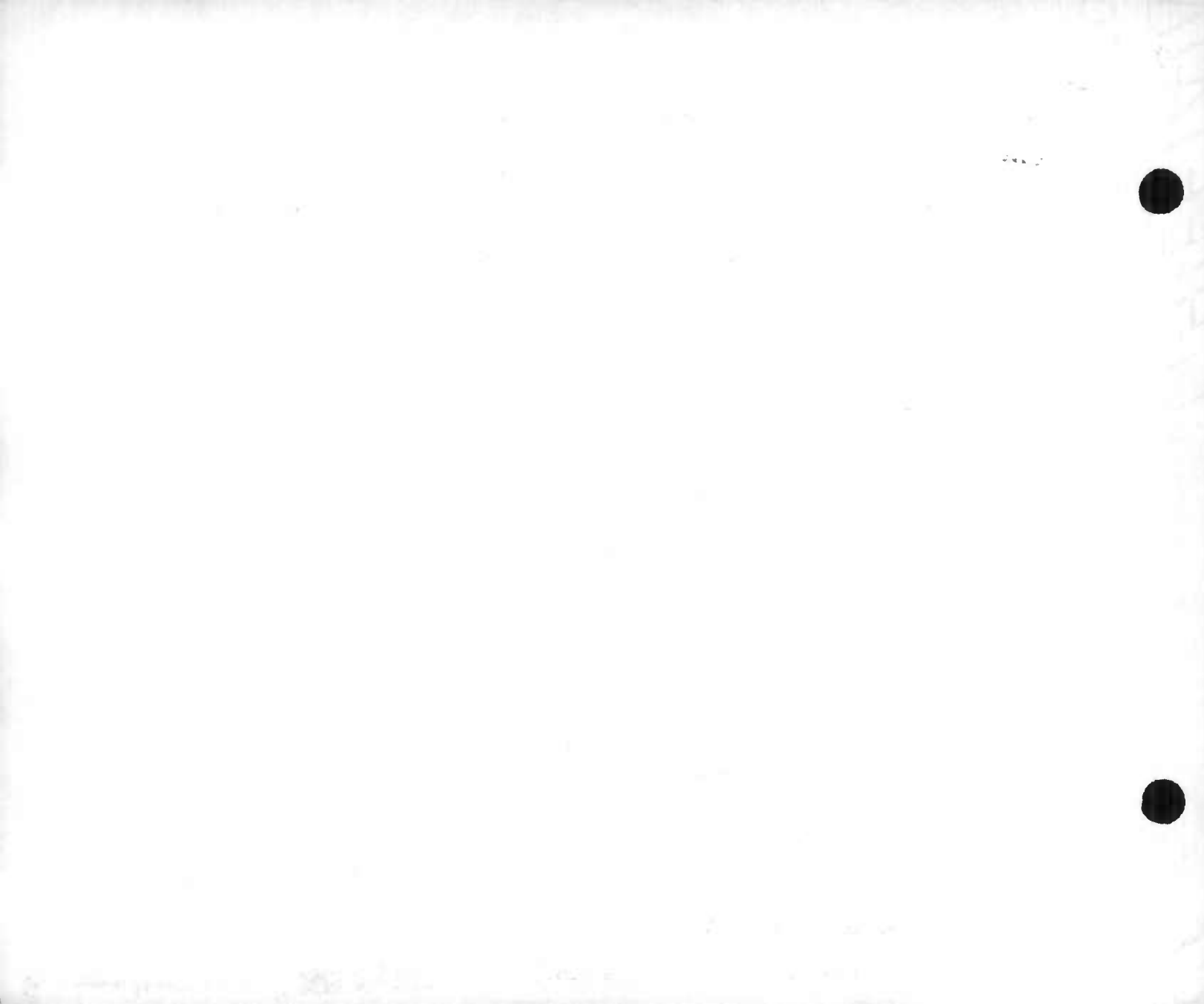
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH X LIMA			2a. DATE OF DEATH MONTH DAY YEAR 12 12 84		2b. HOUR 5:45 A.M.						
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 21 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Insulation			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3452 Carriage Hill Circle 21133		
14. FATHER'S NAME FIRST MIDDLE LAST Congetto Lima				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Bressler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Mrs. Rebecca J. Lima - Same as #13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA - RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS - MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 10-6- 19 84 to 12-12 19 84 , that (I) (we) last saw the deceased alive on 12-12- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27a. SIGNATURE R. DEPESTRE			27b. PHYSICIAN'S NAME (TYPE OR PRINT) R. DEPESTRE			27c. DATE SIGNED 12/12/84			27d. ADDRESS BALTIMORE COUNTY GENERAL HOSP.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12/12/84			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board						25a. DATE REC'D. BY REGISTRAR DEC 2 1984					
25b. REGISTRAR'S SIGNATURE [Signature]											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 32195

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BERTHA V. LINDENMUTH			2a. DATE OF DEATH MONTH DAY YEAR DEC. 12, 1984			2b. HOUR M	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 2/21/19		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.			
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 363 LEANNE RD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21221 363 LEANNE RD		
13a. STATE MD.	13b. COUNTY BALTO	13c. CITY OR TOWN ESSEX					
14. FATHER'S NAME FIRST MIDDLE LAST GUY ULSHAER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH VALENTINE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 213-34-5735		17. INFORMANT ADDRESS LEROY LINDENMUTH ABOVE		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) **Coronary Artery Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

minutes

5+ years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from Feb. 1979 , to December 12, 1984 , that (a) (we) last saw the deceased alive on Sept. 12, 1984 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul Tecklenberg, M.D.				DEGREE M.D.		22c. DATE SIGNED 12-13-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Tecklenberg, M.D.				22e. ADDRESS 9101 Franklin Sq. Dr. / Bkfst. 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL - BURIAL	23b. DATE 12/14/84	23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS LUTH. RITE	23d. LOCATION CITY OR TOWN COUNTY STATE UNIONTOWNSHIP PA.
24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MACE		25a. DATE REC'D. BY REGISTRAR DEC 14 1984	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECTION 10000

SECTION 10000

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

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1 - FOR
STATE
REGISTRAR XC 06050303STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 1 9 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES REESE LINGENFELDER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 11, 1984		2b. HOUR 4:00P^M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 9, 1918	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN	12b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CHRISTOPHER LINGENFELDER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN AUGUSTA Poulson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II	214 01 8349	17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) LEFT HEMIPLEGIA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE / HODGKINS DISEASE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NO! WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 29 19 84 to DECEMBER 11 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 11 19 84 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Elma G. Panizales</i> MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELMA G. PANIZALES, M.D.		22e. ADDRESS VAMC, FORT HOWARD, MD 21052			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/15/84	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222			25a. DATE REC'D. BY REGISTRAR DEC 17 1984	25b. REGISTRAR'S SIGNATURE <i>Asia Davidson-Randall</i>	

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3.2197

FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST ARTHUR D. LISTMAN			2a. DATE OF DEATH MONTH DAY YEAR 12/2/84		2b. HOUR MIN. 6:45AM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9/6/13		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVEN IN FULL) 6701 N. CHARLES STREET (GBMC)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocer		
12b. KIND OF BUSINESS OR INDUSTRY Self-Employed								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 733 B4 Camberley Circle 21204								
14. FATHER'S NAME FIRST MIDDLE LAST George Listman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Dietz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-09-9253		17. INFORMANT ADDRESS Mrs. Dorothy M. Listman 733 B4 Camberley Circle Towson, Md. - 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) UREMIA DUE TO, OR AS A CONSEQUENCE OF (c) LYMPHOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/14/84 84 12/2 84				
22a. I certify that (I) (this hospital) attended the deceased from 11/14/84 19 84 to 12/2 19 84 , that (I) (we) lost the deceased alive on 12/2 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Paula L. Crawford MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/2/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. CRAWFORD				22e. ADDRESS 6701 N. CHARLES ST. (GBMC)				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206				25a. DATE REC'D. BY REGISTRAR DEC 4 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

Carroll, C. J.

= 14,57

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 1 9 8

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Wiley Blaine LITTLE			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1984		2b. HOUR 6:28A M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12/16/09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY STEEL	
13a. STATE M.D.			13b. COUNTY BALTO.	13c. CITY OR TOWN ESSEX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE LITTLE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LALA HURLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. 245 05 0186		17. INFORMANT ADDRESS MYRTLE LITTLE ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Underlying Arteriosclerotic cardiovascular disease (Myocardial infarction) DUE TO, OR AS A CONSEQUENCE OF (c) x2. Status post coronary artery bypass grafts x4)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input checked="" type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from November 28, 1984, to December 10, 1984, that I (we) lost saw the deceased alive on December 10, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.					
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED 12/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Alberto Borges		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/13/84	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY		400 MALE		25a. DATE REC'D. BY REGISTRAR DEC 12 1984	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



12/12/04

W. C. V. H.

RECEIVED - PHARMACY DEPT. HOSP. 7

NOV 24 1904

RECEIVED

DEPT. OF THE ARMY

WASHINGTON

NOV 24 1904

RECEIVED

DEPT. OF THE ARMY

WASHINGTON

NOV 24 1904

RECEIVED

DEPT. OF THE ARMY

WASHINGTON

NOV 24 1904

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 1 9 9

1 - STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		11 25 84		6 ^{PM}	
HARRY LIVERETTE					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	WHITE	MONTH DAY YEAR	75	IF UNDER 24 HRS.	
				MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
North Carolina	USA		Catonsville-BALTIMORE, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Catonsville	Spring Grove Hosp.		Plumber		Private
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Prince George's	Hyattsville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5616 30th AVE. 20782	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
James Liverette	Roxie West				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS	
NO	213-162078	Susan Scott		22124	
		3602 Twilight Ct		Oakton VA	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cancer of the PHARYNX with					
DUE TO, OR AS A CONSEQUENCE OF					
(b) METASTASES					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-8-1976 to 11-25-1984, that (I) (we) last saw the deceased alive on 11-25-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Cesar Valle Caverio M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11-25-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
CESAR VALLE CAVERO		5 Spring Grove Hosp. Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	11/28/84	Cedar Hill Cemetery		CITY OR TOWN COUNTY STATE	
				Suitland PG MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
Robert E Wilhelm Funeral Home		Suitland MD		JUL 0 3 1984	

Game of the Pharynx with
the Fox in the

11-27-28

Game of the Pharynx with
the Fox in the

11-27-28

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				3 2 2 0 0 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		X MONTH DAY YEAR		2b. HOUR	
KEITH S. LOCKNER								12-2-84					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 22, 1959		6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR 2:45A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED X NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County							
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maiden Choice Lane & Paradise		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Dodge Dealer							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES NO		13e. STREET ADDRESS 4753 Chapel Square		21227			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lockner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Naphtain Webb		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220 76 0930		17. INFORMANT Kathleen Lockner		ADDRESS 4753 Chapel Square			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 8159 IMMEDIATE CAUSE (a) Cranio-cerebral trauma Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES X NO									
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-2-84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) occupant of a car which struck a fixed object and overturned									
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK X		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Maiden Choice Lane & Paradise Catonsville, Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident X Suicide Homicide Undetermined manner		Autopsy XX Inspection Inquiry and in my opinion		TITLE (SPECIFY) M.D. Deputy Chief		DATE SIGNED 12-2-84							
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 4, 1984		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Maryland							
24. FUNERAL DIRECTOR NAME Harry H Witzke		ADDRESS 4112 Columbia RD Ellicott City		25a. DATE REC'D. BY REGISTRAR DEC 3 1984		25b. REGISTRAR'S SIGNATURE Julia W. Davidson							

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②

DAVID WHITE

RECEIVED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 0 1
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Alice A. Logue</u>			2a. DATE OF DEATH MONTH <u>12</u> DAY <u>27</u> YEAR <u>84</u>			2b. HOUR <u>M</u>					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>12</u> DAY <u>-07</u> YEAR <u>909</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> <u>-75</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Meridian Nursing Home-Caton</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u></u> 13c. CITY OR TOWN <u>Balto.</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>Balto., Md. 5106 Greenwich Ave. #21229</u>					
14. FATHER'S NAME FIRST <u>Ed</u> MIDDLE <u></u> LAST <u>Griffin</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u></u> LAST <u>Graham</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT <u>902 Alson Drive-Apt. 102 - Balto., Dorothy A. Bangs Md. 21229</u>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis with stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>10 months</u>
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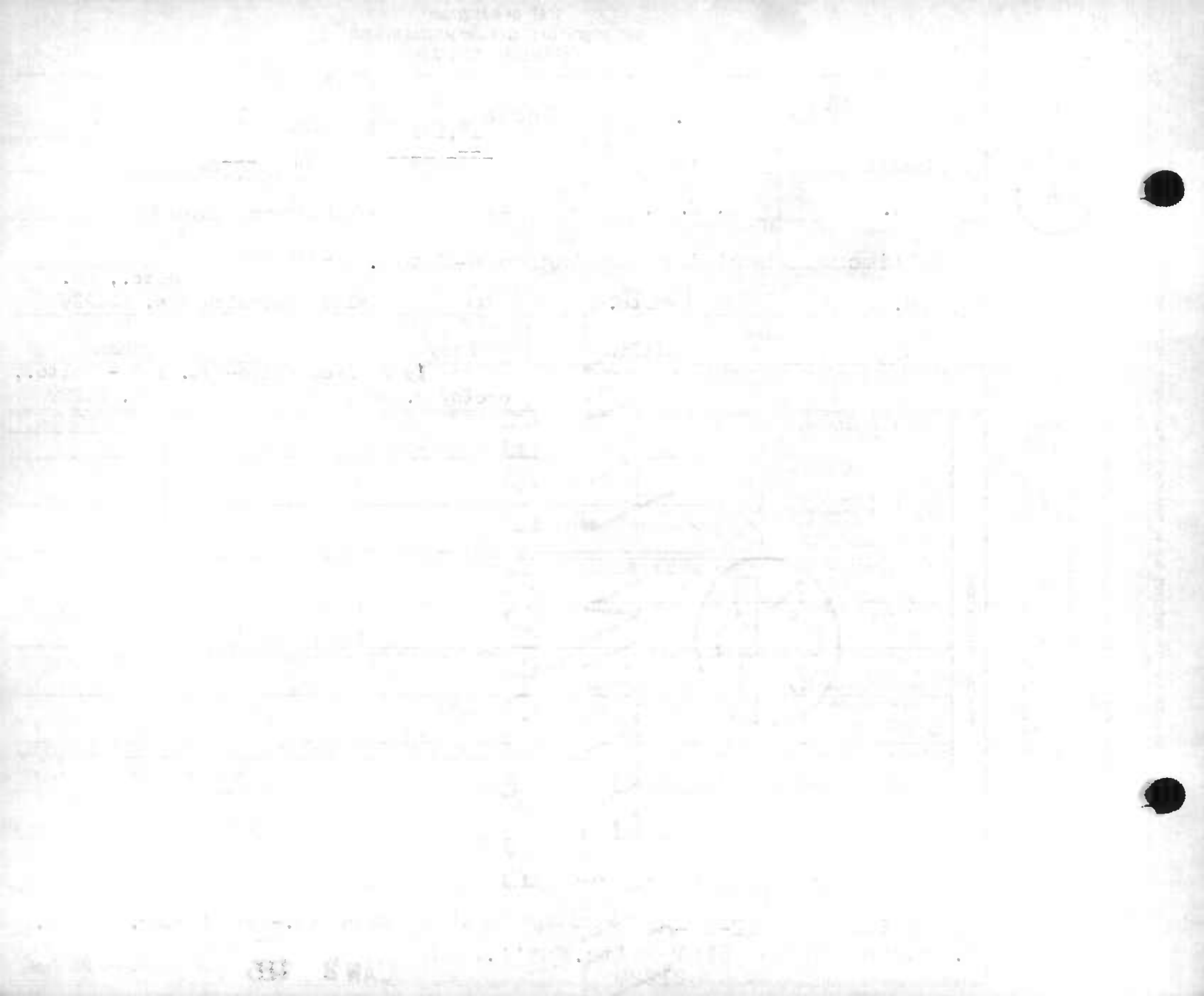
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>XX</u> <u>XXXX</u> attended the deceased from <u>12/10</u> <u>82</u> to <u>12/27</u> <u>84</u> , that (I) <u>XX</u> <u>XXXX</u> saw the deceased alive on <u>12/8</u> <u>1984</u> , and that in (my) <u>XX</u> <u>XXXX</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>XXXX</u> <u>XXXX</u> did not view the body after death.							
22b. SIGNATURE <u>W. K. Gallager, Jr.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>28 December 84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wilmer K. Gallager, Jr., M.D.</u>				22e. ADDRESS <u>3455 Wilkens Avenue-Balto., MD 21229</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-29-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Heritage Baptist Church Cem.-Westminster,</u>		23d. LOCATION CITY OR TOWN <u>Balto.</u> COUNTY <u>Nat'l.</u> STATE <u>Pike</u>	
24. FUNERAL DIRECTOR <u>G. Truman Schwab</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 2 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

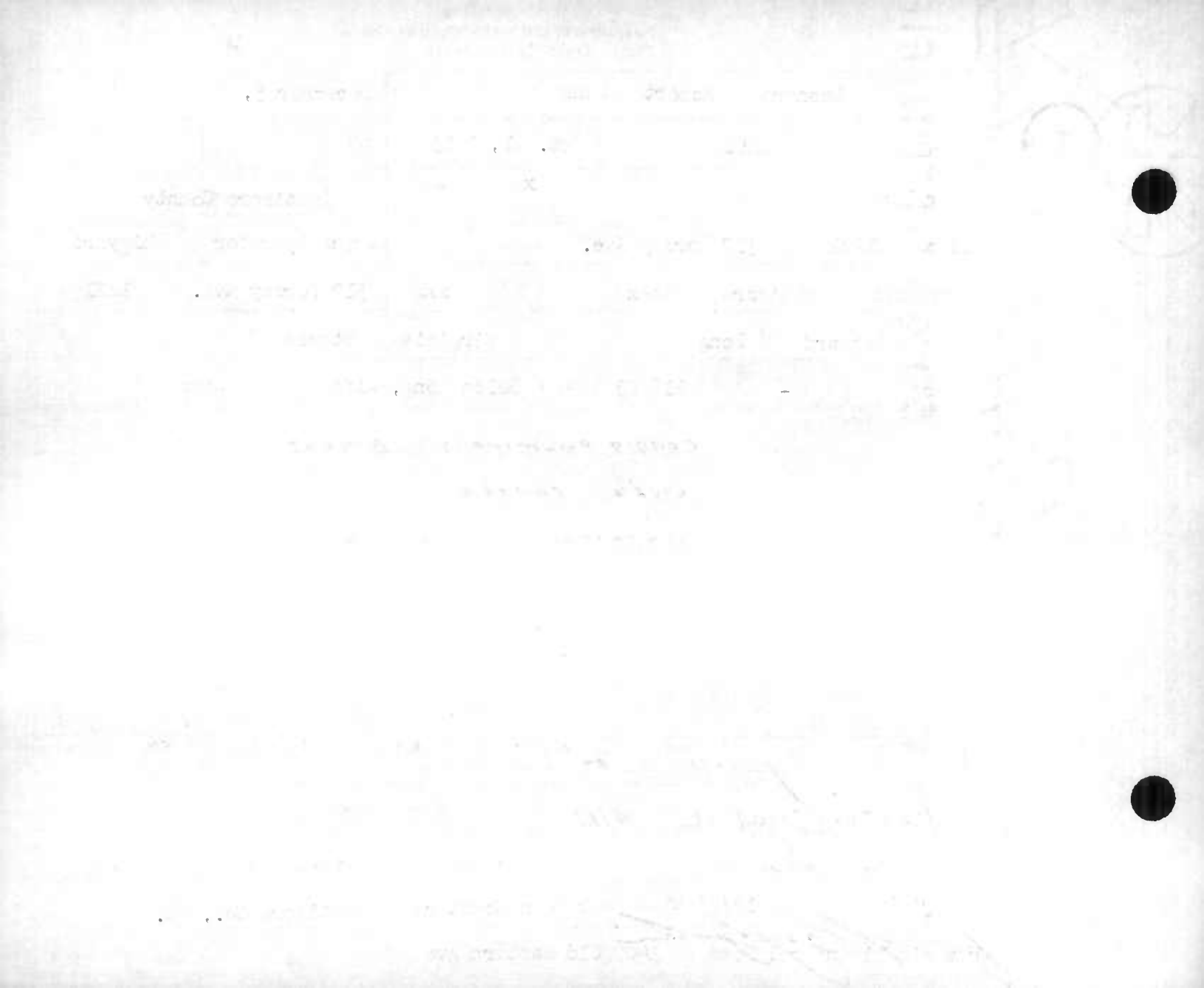
BP_____

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 0 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Leonard Robert Long		2a. DATE OF DEATH December 5, 1984		2b. HOUR	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 21, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
10. CITY OR TOWN OF DEATH Essex 21221		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 517 Dorsey Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator		12b. KIND OF BUSINESS OR INDUSTRY Shipyard	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Essex	
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Long				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Stokes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Helen Long, Wife		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LIVER CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>METASTATIC ASCITES</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> , 19 <u>84</u> , to <u>12/1</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12/1</u> , 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not see the body after death.							
22b. SIGNATURE Keith English MD.				DEGREE MD.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEITH ENGLISH				22e. ADDRESS FRANKLIN SQUARE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR DEC 7 1984		25b. REGISTRAR'S SIGNATURE William Handell	

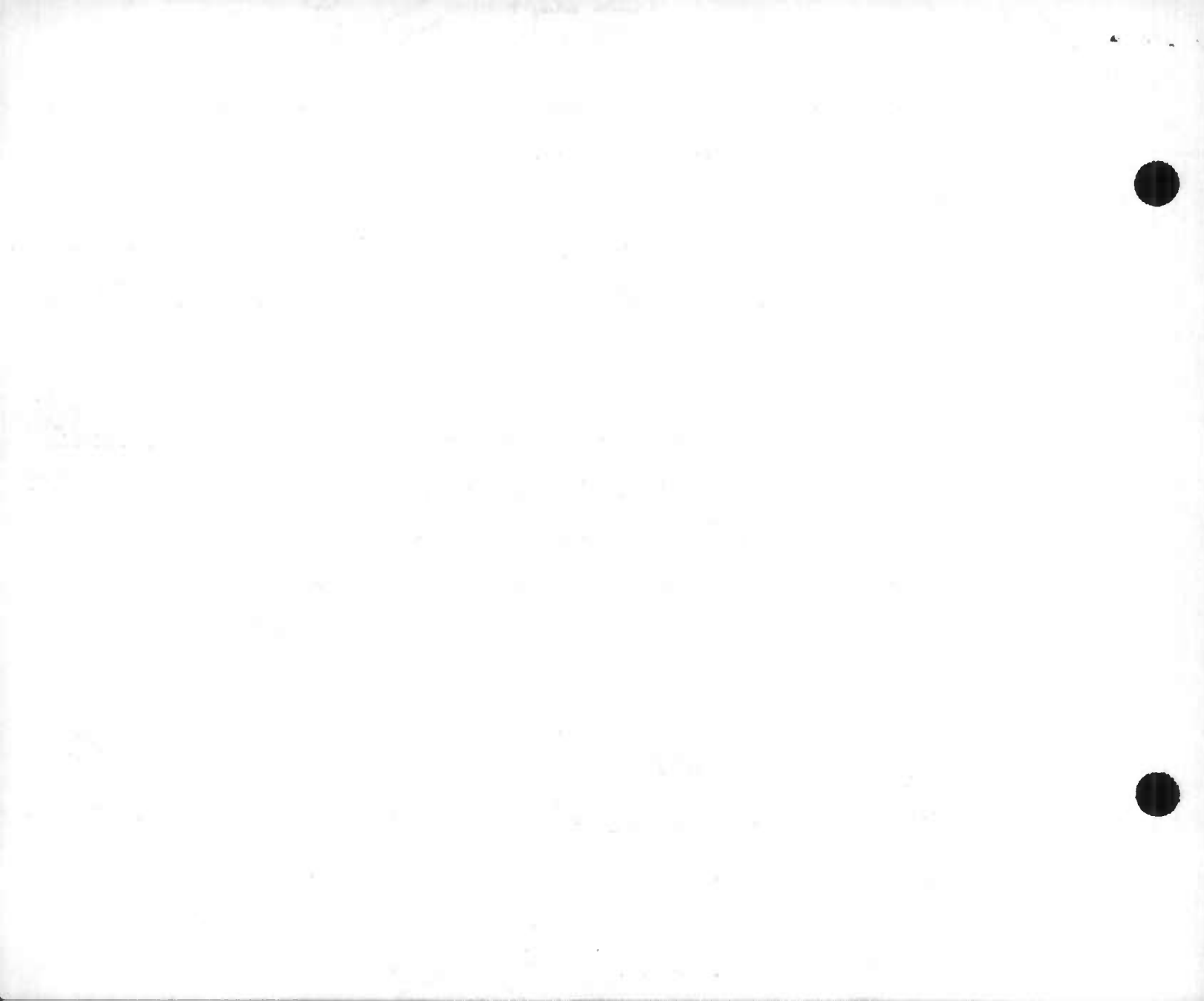


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be called at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 0 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FAY			2a. DATE OF DEATH MONTH DAY YEAR DEC. 21, 1984			2b. HOUR 10 P. M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 5, 1950		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3411 FIELDING RD. (21208)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECTY		12b. KIND OF BUSINESS OR INDUSTRY SOC. SEC. ADM.		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN PIKESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3411 FIELDING RD. #21208	
14. FATHER'S NAME FIRST MIDDLE LAST PAUL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE BIRNBAUM			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 218-50-7134			17. INFORMANT ADDRESS (21215) RABBI HERBERT BIRNBAUM 3414 DEVONSHIRE DR.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO OR AS A CONSEQUENCE OF <i>Suppose Vena Cava Obstruction</i> (b) <i>Metastatic Carcinoma</i> (c) <i>Bilateral Lung Abscesses; Fanconi's Anemia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>1983</i> 19a. DATE OF OPERATION									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from <i>1983</i> 19____ to <i>now</i> 19____, that (b) (we) last saw the deceased alive on <i>12/19/84</i> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (19 (we) (I) did not attend the body after death.									22c. DATE SIGNED <i>12/22/84</i>	
22b. SIGNATURE <i>Donald Pachutta</i>			22e. ADDRESS 2209 FOXHUNT LA. LUTHERVILLE, MD			22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD PACHUTTA, M.D.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/23/84		23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESD		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, BALTO. MD.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 2 0 4	
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)						2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
JAMES BRITTON LOVETT, Jr.						12-31-84		11AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		White		5 30 34		50 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
W. Virginia				U.S.A.				Baltimore County			
11. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Sparrows Pt.				Sparrows/Dispensary				Electrician Welder-Beth.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8201 Shore Road 21222	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
James B. Lovett, Jr.						Mary Virginia Butcher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				234-52-9093				Alice K. Lovett Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Margarita A. Korall, M.D.				M.D. Assistant				12-31-84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Margarita A. Korall, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				1/4/1985		Weston Masonic Cem.				Weston W. Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
7922 Wise Avenue Dundalk, MD. 21222						JAN 2 1985		Julia Davidson-Randall			

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 2 0 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE V. LOWRY			2a. DATE OF DEATH MONTH DAY YEAR 12-02-84		2b. HOUR 3:00 P_M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 20, 1892		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DULANEY TOWSON NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 122 B -Melrose East 21212	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Hardester		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Mitchell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
17. SOCIAL SECURITY NO. 216-46-1480		18. INFORMANT ADDRESS Henry A. Lowry, Jr. -1512 Cranwell Rd. 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ACUTE URINARY TRACT INFECTION					12 hr
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from FEBRUARY 73 to 12-2 , 19 84 , that (I) (we) lost saw the deceased alive on 12-02 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Frank G. Kuehn		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/03/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Frank G. Kuehn		22e. ADDRESS 7600 Osler Dr. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Mausoleum		23b. DATE 12-5-84	23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Baltimore, Maryland
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 5 1984	
25b. REGISTRAR'S SIGNATURE J. H. Davidson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use at the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 other death certificates with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

5
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 0 6
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA A. LUNN			2a DATE OF DEATH MONTH DAY YEAR 12 -23 -84		2b HOUR 7:50 P.M.	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 10 18 43		
6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			10 CITY OR TOWN OF DEATH BALTIMORE			
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
12b KIND OF BUSINESS OR INDUSTRY			13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13b STREET ADDRESS / ZIP CODE 1623 Ralworth Rd. 21218			14 FATHER'S NAME FIRST MIDDLE LAST Mosson A. Scroggins			
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Carter			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No			
16b SOCIAL SECURITY NO. 212-42-1823			17 INFORMANT ADDRESS Andrew Lunn 1623 Ralworth Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Large cell lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Arthur A. Serpick MD		DEGREE MD		22c DATE SIGNED 12/28/84		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Arthur A. Serpick MD		22e ADDRESS Saint Joseph Hosp				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/31/84		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		
23d LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD		24 FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave,				
25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE John Davidson-Randall				

BP

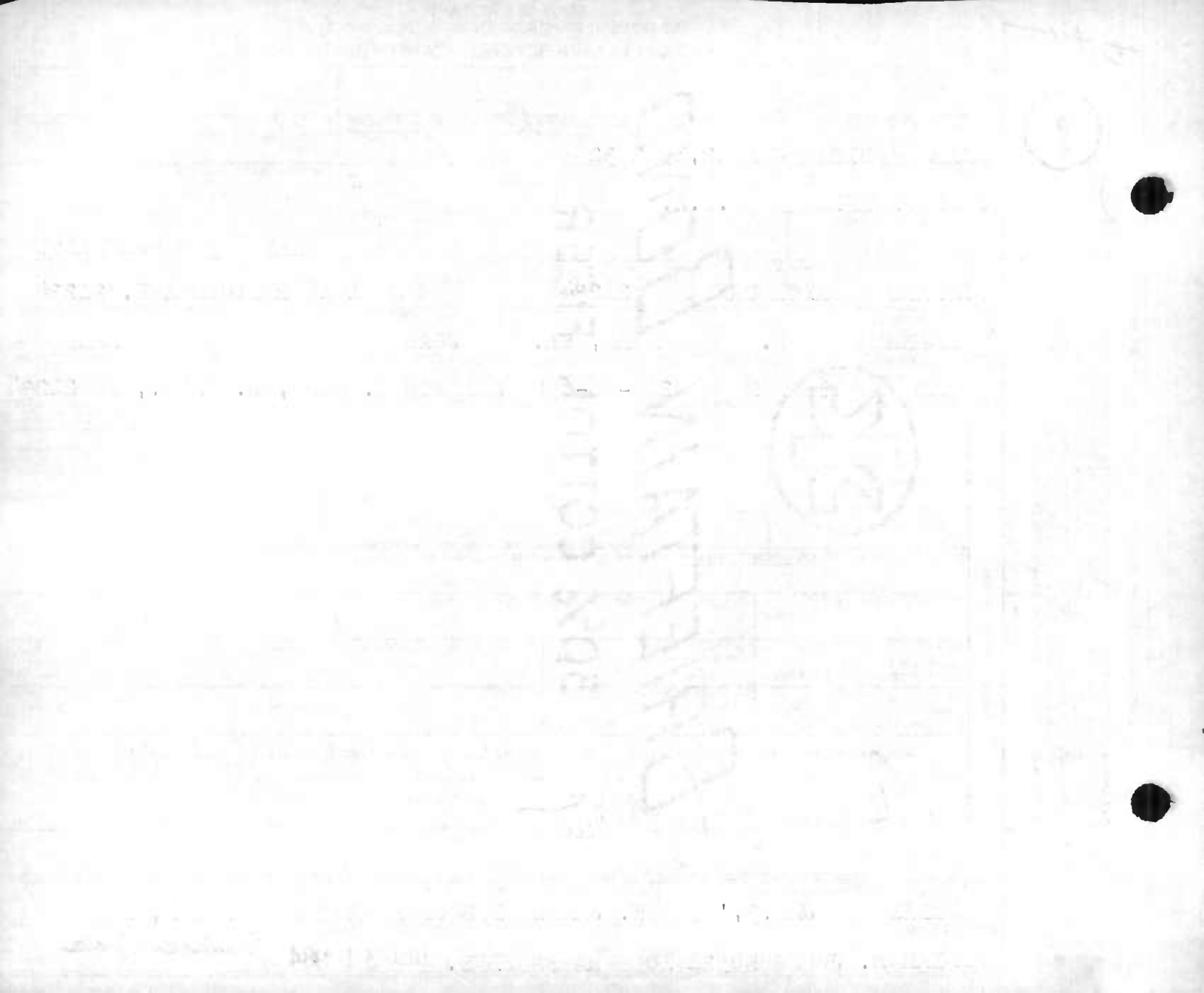


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 2 0 7

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Jeffrey		MIDDLE A.		LAST Maag		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12-29 1984		2b. HOUR M a.m.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 12, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12-30 1984		7d. HOUR 6:46 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.							
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Spring Grove State Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GUARD		12b. KIND OF BUSINESS OR INDUSTRY SECURITY					
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1818 REDWOOD AVE. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST KENNETH R. MAAG, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOAN LAKE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		(IF YES, GIVE WAR OR DATES) VIETNAM		16b. SOCIAL SECURITY NO. 216-66-6906		17. INFORMANT ADDRESS KENNETH R. MAAG, SR. BALTO., MD 21234							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 12-30-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE JAN. 3, '85		23c. NAME OF CEMETERY OR CREMATORY ST. JAMES EPISCOPAL CHURCH				23d. LOCATION CITY OR TOWN COUNTY STATE BRISTOL, PA			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 0 8 REG. NO.					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) BENNY Joseph MACCALLINI										12 02 84				10:10AM	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 5 8 1915			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent			12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1905 Steven Drive 21040			
14. FATHER'S NAME FIRST MIDDLE LAST Pasquale Maccallini						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelina Mazzulli									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 717-12-0412		17. INFORMANT ADDRESS Susanne Riecke 1806 Harkins Road Pylesville, MD 21132							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG (BRONCHOALVEOLAR) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PROSTATIC ADENOCARCINOMA															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11-18 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-18 19 84 to 12-02 19 84 , that (I) (we) last saw the deceased alive on 12-02 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)															
22b. SIGNATURE <i>Ralph W. Fawcett</i>								DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/2/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH W. FAWCETT MD								22e. ADDRESS GBMC 6701 N. CHARLES ST., TOWSON MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/5/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus				23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore MD					
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222								25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE <i>Guth Davidson</i>					

MEDICAL CERTIFICATION

A

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21-2

1-11

2-21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

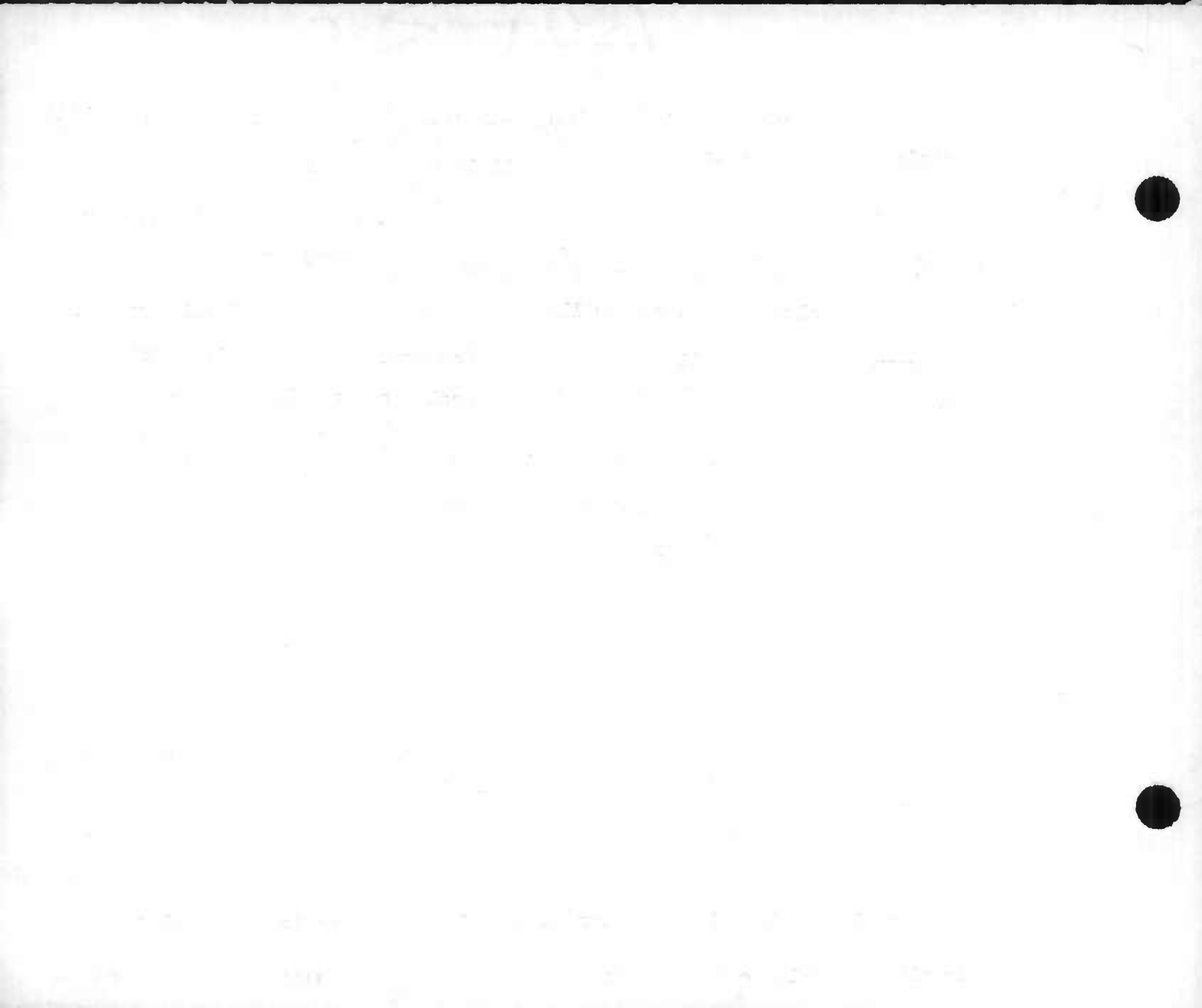
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 2 0 9

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH W. MACNEAL			2a. DATE OF DEATH MONTH DAY YEAR 12-4-84		2b. HOUR MIN. 249 P						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 11 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md			13b. COUNTY Balto		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13801 York Rd. 21030		
14. FATHER'S NAME FIRST MIDDLE LAST Harry W Willson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Blankford								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 46 4600		17. INFORMANT ADDRESS H. Donald Schwaab 10 Light St - 21202							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute anterior MI with electro-mechanical dissociation DUE TO, OR AS A CONSEQUENCE OF (b) Coronary art. dis. DUE TO, OR AS A CONSEQUENCE OF (c) Cadaver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18											
19a. DATE OF OPERATION 2 9			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/2 , 19 84 , to 12/4 , 19 84 , that (1) (we) lost sight of the deceased on 12/4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE L. D. Antonio M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/4/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 7401 OSCEOLA Drive Suite 210 Towson Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-8-1984		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto Md			
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Rd.						25a. DATE REC'D. BY REGISTRAR DEC 12 1984		25b. REGISTRAR'S SIGNATURE K. Anderson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove cardboard pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 1 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sophie Mac Pherson		2a. DATE OF DEATH MONTH DAY YEAR 12-29-84		2b. HOUR 2:00 P.M.	
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05-01-03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.	
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE Rossville NURSING center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Brecht		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Meyers		16. STREET ADDRESS / ZIP CODE 825 S. Woodlynn Rd. 21221	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 18 1999		17. INFORMANT ADDRESS Dolly Bocht, Daughter Balto., Md. 21221	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(b) **SENIOR DEMENTIA**

DUE TO, OR AS A CONSEQUENCE OF

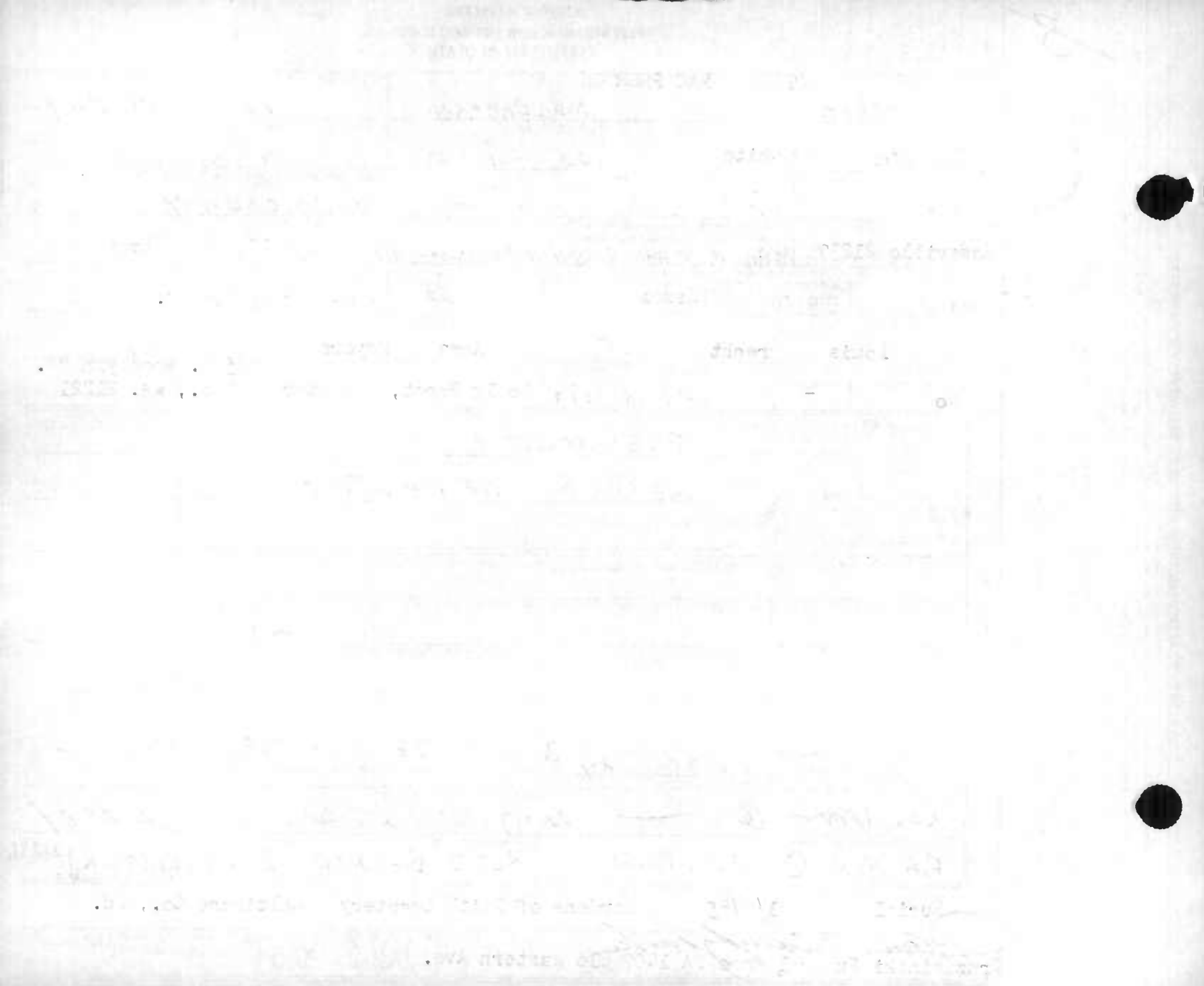
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 3 , 19 78 , to 12-29 , 19 84 , that (I) (we) last saw the deceased alive on 12-28 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE BA YIN OUNG, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-29-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BA YIN OUNG, M.D.				22e. ADDRESS 8022 BELAIR ROAD. BALTO. MD. 21236			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/2/85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR Brzezinski Funeral Home PA 1407 Old Eastern Ave.				25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE Gina Davidson-Randell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 2 1 1

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BASILIDES A MADARANG			2a. DATE OF DEATH MONTH DAY YEAR 12-5-84		2b. HOUR 4:39 PM
3. SEX Female	4. RACE Oriental	5. DATE OF BIRTH MONTH DAY YEAR 1 1 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	7. UNDER 1 YEAR MONTHS DAYS 66
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILIPPINES	7b. CITIZEN OF WHAT COUNTRY? PHILIPPINES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1505 Long Quarter Court 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Aguido Alivio		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teodora Managase			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 218-04-3684	17. INFORMANT ADDRESS Mr. Alfonso A. Madarang, Jr. same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12-5-84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-5-84 to 12-5-84 that (I) (we) last saw the deceased alive on 12-5-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A.H. Ghiladi		DEGREE MD		22c. DATE SIGNED 12-5-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.H. GHILADI, MD.		22e. ADDRESS 7600 OSLER Dr. Towson 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/10/84	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Towson Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR DEC 7 1984	
				25b. REGISTRAR'S SIGNATURE John Davidson-Rendall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove color-bar papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES A. MAGGIO			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 14, 1984			2b. HOUR 12:30 A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR June 21, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SANT JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SERVICE MAN		12b. KIND OF BUSINESS OR INDUSTRY Oil	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MARYLAND BALTIMORE PARKVILLE				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 3204 ACTON ROAD 21234	
14. FATHER'S NAME FIRST MIDDLE LAST William S. MAGGIO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AOELLA Young			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 03 6502		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Hyper-tensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Heating P. Dizon, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 17, 1984		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPL OF MEMORIALS HARFORD RD.				25a. DATE REC'D. BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 1 3 REG. NO.					
1. FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST (Sister) Mary Gerald Maher										2a. DATE OF DEATH MONTH DAY YEAR Dec. 27, 1984				2b. HOUR 9 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.									
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Villa Assumpta, 6401 N. Charles				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6401 N. Charles St. 21212							
14. FATHER'S NAME FIRST MIDDLE LAST Michael Joseph Maher					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget Connors										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-54-9802		17. INFORMANT ADDRESS Sk. Angelina Catina - same											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Continues</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>June 78</u> , to <u>Dec. 27</u> , 19 <u>84</u> , that (I) <u>(we)</u> saw the deceased alive on <u>Dec. 27</u> , 19 <u>84</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> did not view the body after death.															
22b. SIGNATURE <u>L. Boas</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/27/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawrence Boas, M. D.				22e. ADDRESS 54 Scott Adam Rd., Cockeysville 21030											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Sister's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Arm, Balto., Md.									
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld H ^U me				ADDRESS 6500 York Road 21212				25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>					

UNITED STATES DEPARTMENT OF JUSTICE

IN RE: [illegible]
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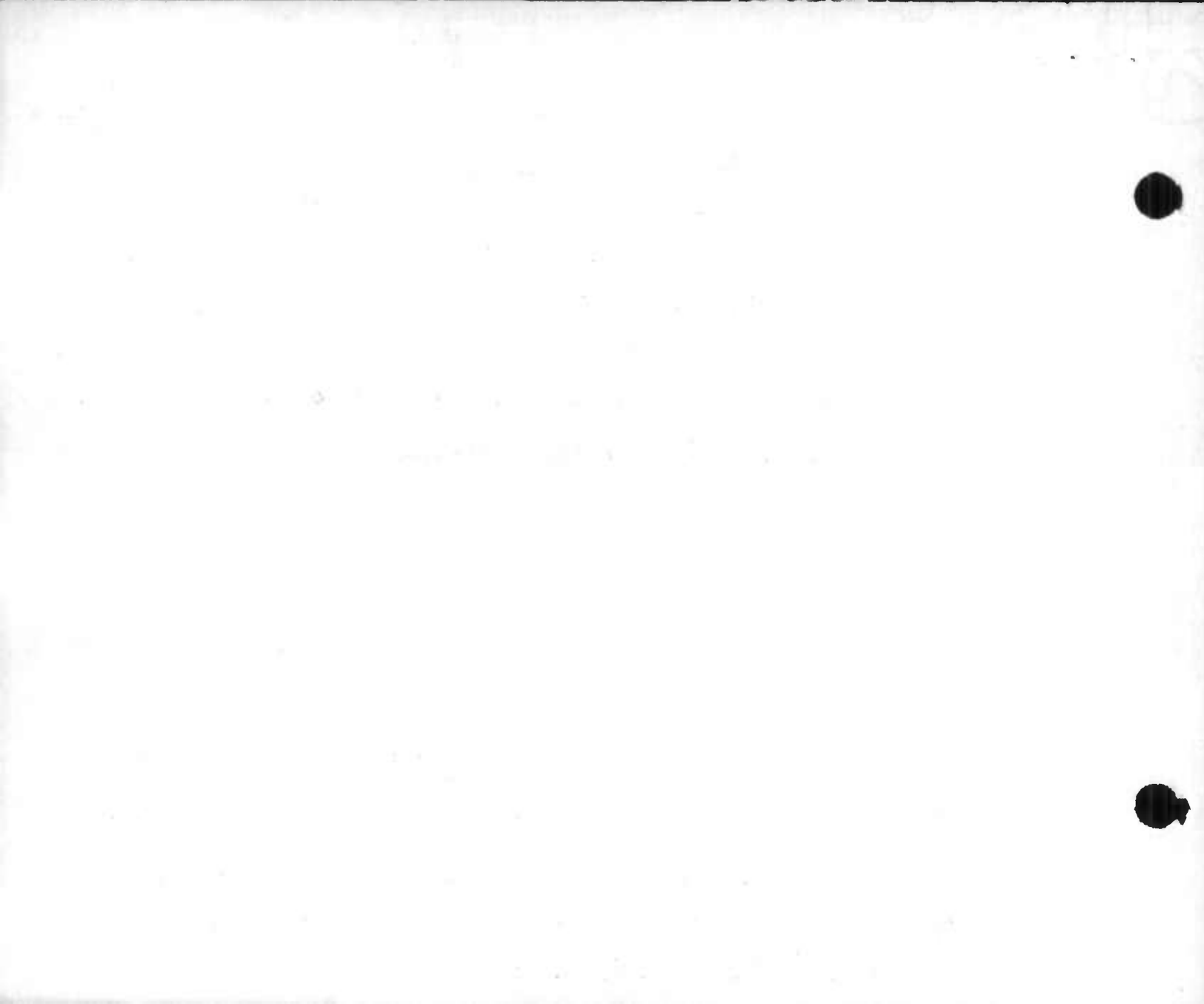
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					3 2 2 1 4 REG. NO.	
1- FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR	
			LENA MAISEL		DECEMBER 23, 1984	
3 SEX			4 RACE		5 DATE OF BIRTH MONTH DAY YEAR	
FEMALE			WHITE		MARCH 29, 1907	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
NEW YORK			USA		77 YRS.	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH	
PIKESVILLE			8203 ANITA RD. (21208)		BALTIMORE COUNTY MD.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
HOUSEWIFE			HOME MAKER			
13a STATE			13b CITY OR TOWN		13c STREET ADDRESS / ZIP CODE	
MARYLAND			BALTIMORE		8203 ANITA RD. (21208)	
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
GERSHON LUSTMAN			IDA RICHTER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
NO			218-26-1018A		MRS. BERNICE SOLOMON 2312 SUGARCONE RD (21209)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <u>Metastatic Uterine Adenocarcinoma</u> <u>Seventyrs</u>						
DUE TO, OR AS A CONSEQUENCE OF (b) _____						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>83</u> to <u>Dec.</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>Nov. 1</u> 19 <u>84</u> , and that in (my) <u>—</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>—</u> (did not) view the body after death.						
22b SIGNATURE <u>Marshall A. Levine</u>				DEGREE <u>MD</u>		22c DATE SIGNED
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/24/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS		
MARSHALL A. LEVINE				711 W. 40th St. BALTIMORE, MD.		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE
BURIAL		12/24/84		ARLINGTON CEMETERY		BALTIMORE, MD.
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE <u>Paulson-Randall</u>
				JAN 3 1985		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 1 5 REG. NO.							
1- FOR STATE REGISTRAR				7a. DATE OF DEATH MONTH DAY YEAR				7b. HOUR M			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH MARESH				12/29/84				4:45AM			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12/30/28		6. AGE IN YEARS (LAST BIRTHDAY) 55		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) 6701 N. CHARLES SR. (GBMC)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Oper. Engineer		12b. KIND OF BUSINESS OR INDUSTRY Tidewater Con.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5819 Pine Hill Dr. White Marsh 21162			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph W. Maresh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Elva RUFANER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 217-26-2891		17. INFORMANT ADDRESS E. Elizabeth Maresh 5819 Pine Hill Dr. 21162					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) LUNG METASTASIS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) COLON CA											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/5 , 19 84 , to 12/29 , 19 84 , that (I) (we) lost above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Labato DEGREE								22c. DATE SIGNED 12/29/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LABATO								22e. ADDRESS 6701 N. CHARLES ST. (GBMC)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-2-85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gard.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				24b. ADDRESS 7401 Belair Rd. BALTO MD. 21236		25a. DATE REC'D. BY REGISTRAR JAN 4 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 2 1 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>LUTIE Haynie MARSH</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>Dec 31 '84</u>		2b. HOUR <u>6:55</u> M
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>2-16-1892</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>92</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>
10. CITY OR TOWN OF DEATH <u>Towson</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dulaney Towson Nsg Center</u>		
13a. STATE <u>MD.</u>			13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Northton</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Robert Bernard Haynie</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mittie Edward Shipley</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>223-13-3542</u>		17. INFORMANT ADDRESS <u>Mrs. William C. Lunsford, Jr. 1913 Knollton Rd. Timonium, MD</u>
18. CAUSE OF DEATH (Enter only one cause per line. Part I, II, and III are mutually exclusive.)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Excess Volume Cardiac Knowledge Disease Heart</u> DUE TO, OR AS A CONSEQUENCE OF <u>Diabetes Mellitus</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>27-Dec-1984</u> to <u>Dec 31 1984</u> , that (I) (we) lost the deceased alive on <u>Dec 31 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Walter T. Kees</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>12/31/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Walter T. KEES</u>		22e. ADDRESS <u>Monkton Md 21111</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1-3-1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Roseland Cemetery</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Readville Northumberland VA.</u>		24. FUNERAL DIRECTOR <u>JAMES A. JONES - A.S.H. Funeral Home</u>			
25. DATE REC'D BY REGISTRAR <u>7 1985</u>		26. REGISTRAR'S SIGNATURE <u>John Davidson</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 1 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Dorothy C. MARSTELLER				2a. DATE OF DEATH MONTH DAY YEAR December 19, 1984				2b. HOUR 12:15^a_M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. CITY OR TOWN Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis J. Creegan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Flanagan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-18-3254		17. INFORMANT ADDRESS Mr. David K. Marsteller S me					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Assystole; Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 18, 1984 to December 19, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 19, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE Fernando J. Acle, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fernando J. Acle, M.D.				22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 21, 1984		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 20 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Randall			

7

RECEIVED

1950
JAN 10 1950
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE ASSISTANT SECRETARY
FOR AGRICULTURAL MARKETING
DIVISION OF MARKET ECONOMICS
UNIT OF MARKET ECONOMICS
WASHINGTON, D.C.
1950

MEMORANDUM FOR THE ASSISTANT SECRETARY
FOR AGRICULTURAL MARKETING
FROM: [illegible]
SUBJECT: [illegible]

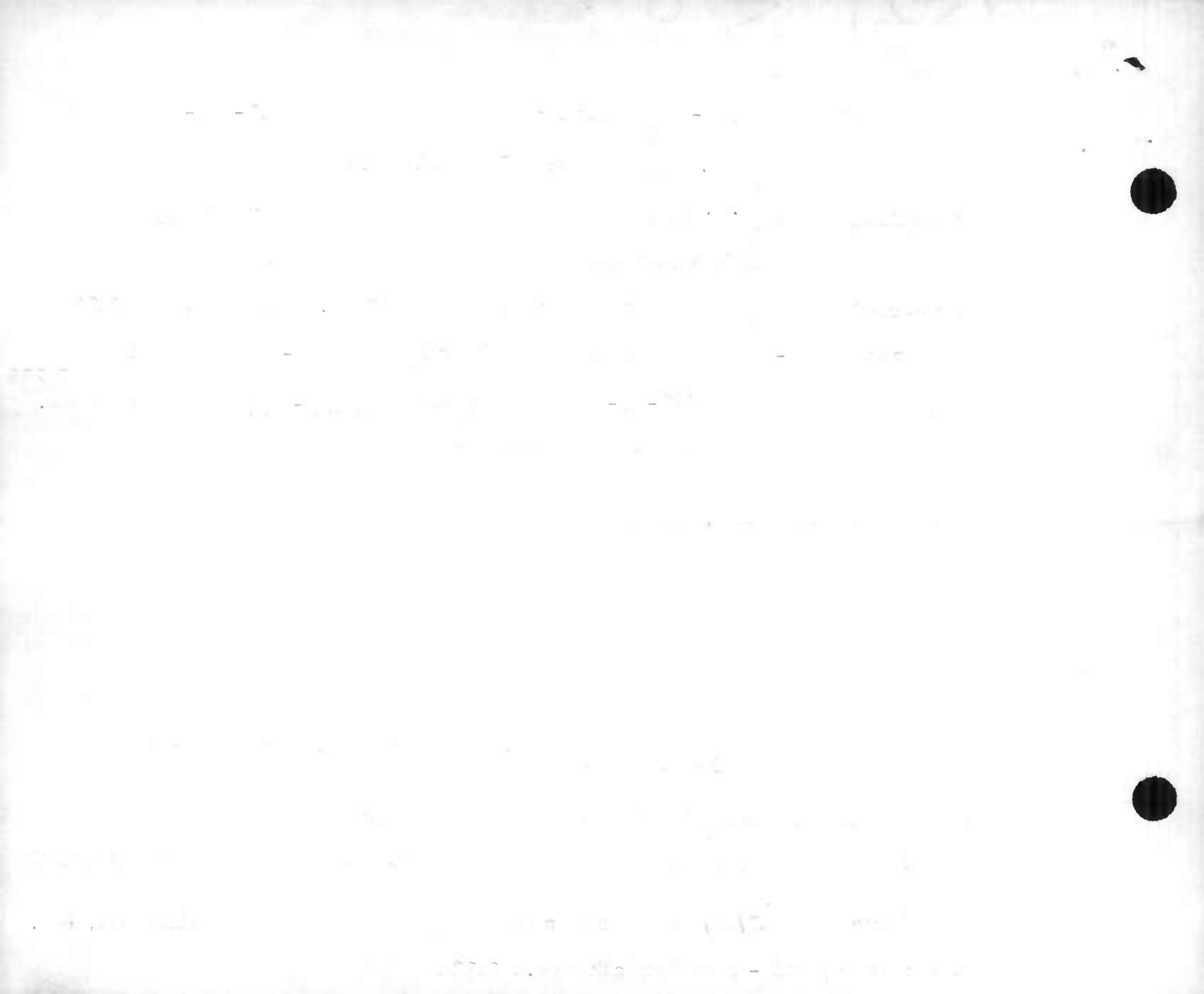
1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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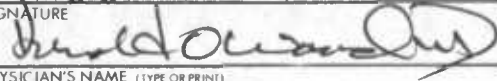

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 1 8	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Sally - Martowski					12- 11- 84					12 ¹⁵ AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS.	
Female		Cauc.		09 27 1894		90 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
		Meridan Heritage				Homemaker					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Highlandtown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				720 S. Elwood Avenue 21224		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Michael - Rozanski			Rosalie - ?			No			213-09-5301		
17. INFORMANT			ADDRESS			21222			Elizabeth Kahlepp - 6706 Youngstown Av.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARCINOMA LUNG											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from NOV 84, to DEC 84, that (I) (we) lost											
saw the deceased alive on 12-1-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
A. CHATTERJEE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
A. CHATTERJEE			3927, ANNAPOLIS ROAD			21227.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial			12/14/84		Oak Lawn		Baltimore, Md.				
24. FUNERAL DIRECTOR										DEC 17 1984	
NAME ADDRESS										Julia Davidson-Randall	
Walter Dabrowski - 1005 Dundalk Ave., 21224											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 1 9 REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILBUR MARTIN LUTHER MAURATH, SR.						DECEMBER 1, 1984				M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 21, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 Acorn Circle Apt. 201				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Food Store			
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11 Acorn Circle 21204			
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Maurath						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Esther Meixel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 212-03-1725A		17. INFORMANT ADDRESS Irene E. Maurath Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Urinary tract infection										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DUE TO, OR AS A CONSEQUENCE OF (b) Bladder incontinence--catheter DUE TO, OR AS A CONSEQUENCE OF (c) Senile brain syndrome </div> <div style="width: 45%; text-align: right;"> 2 years </div> </div>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Recurrent aspiration pneumonitis, secondary esophageal motor dysfunction											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from August 23 , 19 71 , to December 1 , 19 84 , that (I) (we) last saw the deceased alive on November 9 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/3/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald O. Wood, M.D.		22e. ADDRESS 2 Greenmeadow Drive Timonium, Maryland 21093									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 4, 1984		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto. Co., Md.					
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE 					

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked yes, item 18 yes is required. The medical examiner must be notified at once.DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 2 0 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anton Mayrhofer										2a. DATE OF DEATH MONTH DAY YEAR December 20, 1984				2b. HOUR 2:20 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 6, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. UNDER 1 YEAR MONTHS DAYS 0 0		8. UNDER 24 HRS. HOURS MIN. 0 0					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.									
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butler		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Anne Arun.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 525 Westway 21061					
14. FATHER'S NAME FIRST MIDDLE LAST Anton Mayrhofer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Haberpointner										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 054-12-9192		17. INFORMANT ADDRESS Maria Roberson same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SIP CEREBRAL VASCULAR ACCIDENT										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC URINARY TRACT INFECTION DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NO															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Edward P. Kozar						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward P. Kozar						22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 21 Dec. 84		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. MD.							
24. FUNERAL DIRECTOR NAME James S. Kirkley						ADDRESS Glen Burnie MD.		25. DATE REC'D. BY REGISTRAR DEC 21 1984				26. REGISTRAR'S SIGNATURE J. Davidson			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 2 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS P. MC CANN						2a. DATE OF DEATH MONTH DAY YEAR 12 13 '84				2b. HOUR 2:42P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 25. 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		7. IF UNDER 24 HRS HOURS MIN. 0 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.B.M.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Martins					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 202 One Smeton Place 21204			
14. FATHER'S NAME FIRST MIDDLE LAST James J. McCann, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Gunlach									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-09-3789		17. INFORMANT ADDRESS Gloria M. McCann - Same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GI hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1d													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>19 82</u> , to <u>11/27</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Th. Ferciot</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Ferciot M.D.						22e. ADDRESS 311 Oakdale Road, Baltimore, Md. 21209							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-17-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.						ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

BP

Handwritten mark resembling a stylized 'A' or 'B' inside a circle.

RECEIVED
NOV 10 1904

Handwritten text, possibly a date or reference number, written vertically.

Faint, mostly illegible handwritten text covering the majority of the page, appearing to be a letter or document.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 2 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVELYN A MCCARTY			2a. DATE OF DEATH MONTH DAY YEAR 12/10/84		2b. HOUR 2:10 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-26-1923	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS MONTHS DAYS		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12134		
13a. STATE Md.	13b. COUNTY Balto	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8913 Waltham Woods Rd. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Langer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily Clayton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-18-0057		17. INFORMANT ADDRESS Darlene Lorenz, 7822 HighPoint Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (i) (this hospital) attended the deceased from 12/7 84 to 12/10 84 , that (ii) (we) last saw the deceased alive on 12/10 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (they) did not view the body after death.					
22b. SIGNATURE DR. C. CUMMINGS		DEGREE MA		22c. DATE SIGNED 12-10-84	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. C. CUMMINGS		22f. ADDRESS GBMC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-14-84	23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.			25a. DATE REC'D. BY REGISTRAR DEC 11 1984		
25b. REGISTRAR'S SIGNATURE Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 2 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) OLGA C. McCASLIN			2a. DATE OF DEATH MONTH 12 DAY 25 YEAR 84			2b. HOUR 8:30 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 03 DAY 08 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO County, MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Black & Decker Co,		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 200 B Dennybrook Lane 21204	
14. FATHER'S NAME FIRST William MIDDLE Henry LAST Cox				15. MOTHER'S MAIDEN NAME FIRST Neomi MIDDLE L. LAST Grafton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-01-9916		17. INFORMANT NAME William E. Cox ADDRESS Same as #13.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -- yrs
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Dehydration.

19a. DATE OF OPERATION 6/14/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 6/14/84 to 12/25/84 , that (we) last saw the deceased alive on 12/25/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William E. Cox		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEHN M. TUN				22e. ADDRESS MANOR CARE Ruxton.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1984		23c. NAME OF CEMETERY OR CREMATORY Fairview Meth. Cemetery		23d. LOCATION CITY OR TOWN Sunnybrook Balto., Md. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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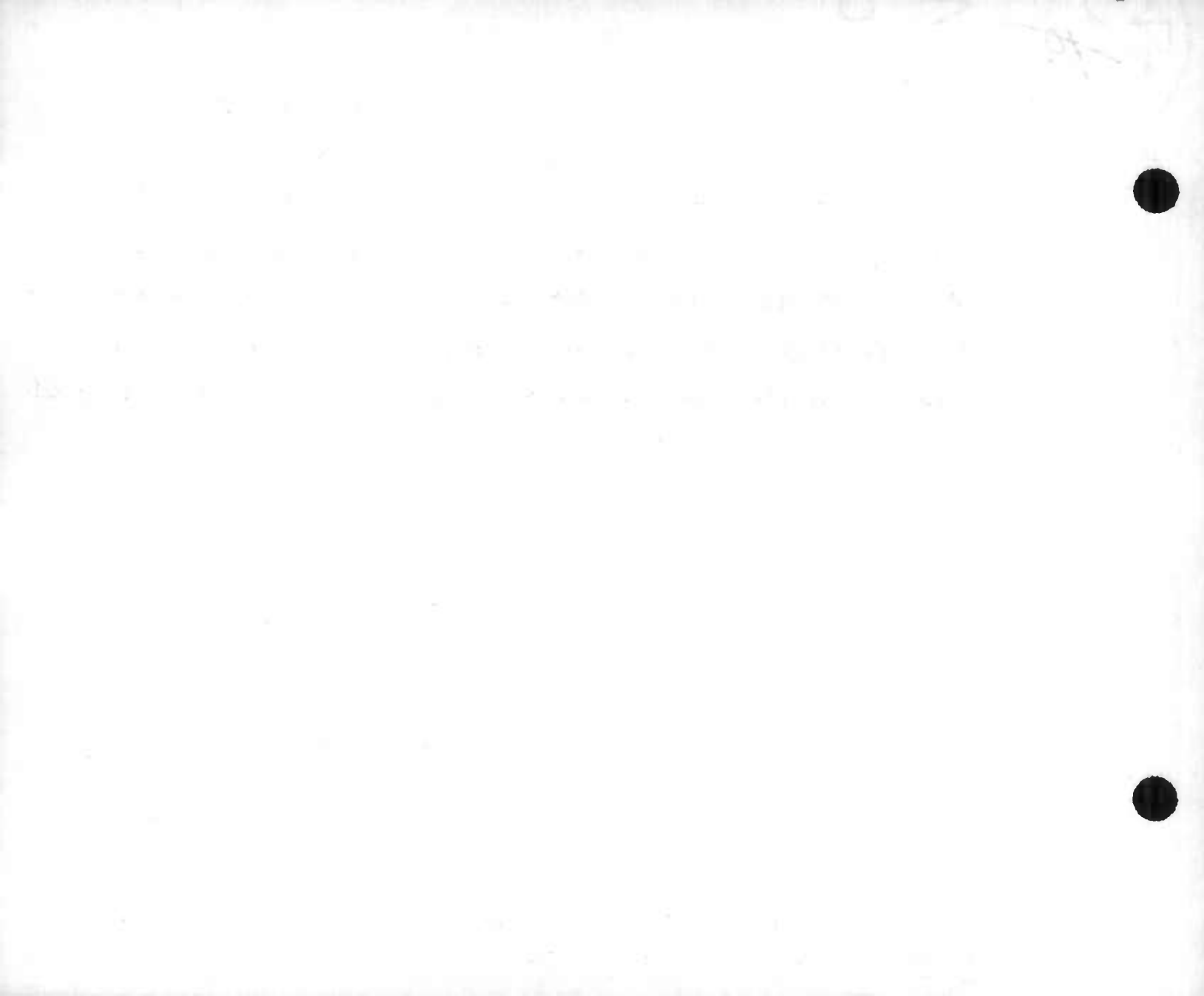
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 2 2 4

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
William Larkin McCullough		12-16-84			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Black	MONTH DAY YEAR	76	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Columbia, S.C.	U.S.A.		County Balto. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Turners Stat.	116 Sollers Point Rd.		Food Service		Food
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS	13d. STREET ADDRESS / ZIP CODE		
13a. Md.	13b. Balto	13c. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. 116 Sollers Pt. Rd. 21222		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
FIRST MIDDLE LAST	FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.		
W. William McCullough	E. Ellen McCullough		16b. 060-12-8691		
17. INFORMANT		17. ADDRESS			
KATHRYN McCullough		116 Sollers Pt. Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Myelomonocytic leukemia					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from 19 82 to present 19, that (b) (we) last saw the deceased alive on 10/31/19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Larry Waterbury, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
LARRY WATERBURY, M.D.		FSK HOSPITAL, BALTO., D.O.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12-20-84		Crownsville V.A.	
				Crownsville, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James A. Morton & Sons 1701 Laurens		DEC 20 1984		Julia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 2 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Della Marie McCoy			2a. DATE OF DEATH MONTH DAY YEAR December 18, 1984		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 21, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 54	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Middle River	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) 4 "A" Mersey Court	12a. USUAL OCCUPATION (TYPE OF MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 4 "A" Mersey Court 21220	
14. FATHER'S NAME FIRST MIDDLE LAST W. B. Hayth			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Gullispie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 227 36 2591		17. INFORMANT ADDRESS Gerald M. McCoy, Sr. Husband Same	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

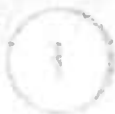
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 19 83 to 12 19 84, that (1) (we) lost saw the deceased alive on 12/10/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE S. Milner	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/20/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Milner		22e. ADDRESS 5400 Old Old Court Rd 21133	

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 12/21/84	23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.
24. FUNERAL DIRECTOR S. Milner		25a. DATE REC'D. BY REGISTRAR DEC 20 1984	25b. REGISTRAR'S SIGNATURE [Signature]



6, FilmG599 1/10/85 mtb

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 2 2 6

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET M. McDERMOTT

2a. DATE OF DEATH MONTH DAY YEAR December 31, 1984

2b. HOUR 12:13AM

1. SEX Female

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR April 6, 1904

6. AGE (IN YEARS LAST BIRTHDAY) 85 80 YRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager

12b. KIND OF BUSINESS OR INDUSTRY Hotel

13a. STATE Maryland

13b. CITY OR TOWN Baltimore

13c. STREET ADDRESS / ZIP CODE 1 West Franklin Street 21201

14. FATHER'S NAME FIRST MIDDLE LAST James E. Bloom

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hamberger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 192-14-1392 A

17. INFORMANT ADDRESS 8916 Chantel Ct. Margaret M. Cook Ellicott City, Md. 21043

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cholecystic Neck Tumor
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Senile Dementia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Senile Dementia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WITH ☐ AT WORK ☐ NOT WHILE AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/1 to 12/31, 1984, that (I) (we) last saw the deceased alive on 12/31, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Robert B. Kroopnick

DEGREE M.D.

22c. DATE SIGNED 12/31/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Kroopnick M.D.

22e. ADDRESS Suite 203 95 Aquahart Road, Glen Burnie, Md. 21061

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 1/2/85

23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.

24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JAN 2 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified and the death certificate must be signed by a medical examiner.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8 4

REG. NO. 3 2 2 2 7

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy MCGRAW		2a DATE OF DEATH MONTH DAY YEAR 12/4/84		2b HOUR 4 35 A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 14 1924		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 60	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Towson 21204		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella MARIS Hospice		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b KIND OF BUSINESS OR INDUSTRY Plastic Co.	
13a STATE Maryland		13b CITY OR TOWN Jarrettsville		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS / ZIP CODE 1347 Rockridge Rd. 21084	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Lynch		15 MOTHER'S MAIDEN NAME Elizabeth Williams		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 217 12 3431	
17 INFORMANT Donald W. McGraw, Son		ADDRESS Same		18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 11/5, 19 84, to 12/4, 19 84, that (I) (we) last saw the deceased alive on 12/4, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Kendall Faulkner, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/4/84			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kendall Faulkner, MD		22e ADDRESS Stella MARIS Hospice, Dulaney Valley Rd.					
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 12/6/84		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24 FUNERAL DIRECTOR Brzezinski Funeral Home PA 1400		25a DATE REC'D. BY REGISTRAR DEC 4 1984		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 2 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beatrice H. McKay		2a. DATE OF DEATH MONTH DAY YEAR December 3, 1984		2b. HOUR 3:00 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 16, 1907	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Balto. County		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6913 B Donachie Road		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Secretary		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Cleveland R. Hoke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes M. Rosensteel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-14-4912		17. INFORMANT ADDRESS Patricia M. Doyle - 308 Elinor Ave. 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia and respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) metastatic small cell bronchogenic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> , 19 <u>84</u> , to <u>11</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Guillermo Vanegas</i>		DEGREE		22c. DATE SIGNED <u>12/3/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Guillermo Vanegas, M.D.		22e. ADDRESS 7600 Osler Drive Towson, Maryland 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-84		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 2 2 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLYN M. McKIM				2a. DATE OF DEATH MONTH DAY YEAR DEC. 1, 1984			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2/3/23		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 346 UPPERLANDING RD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BORTNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 215-12-8721		17. INFORMANT ADDRESS JERRY RICKER 964 SEMCA PK. RD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Tumor DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/14, 1984, to 11/9, 1984, that (I) (we) lost saw the deceased alive on 11/9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Tah-Hsiung Hsu		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TAH-HSIUNG HSU		22e. ADDRESS 1900 E. Northern Parkway Baltimore 21239					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/4/84		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY		ADDRESS 300 MACE AVE		25a. DATE REC'D. BY REGISTRAR DEC 4 1984		25b. REGISTRAR SIGNATURE J. J. [Signature]	

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PAKIA 1-14/84 HORTA HIR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

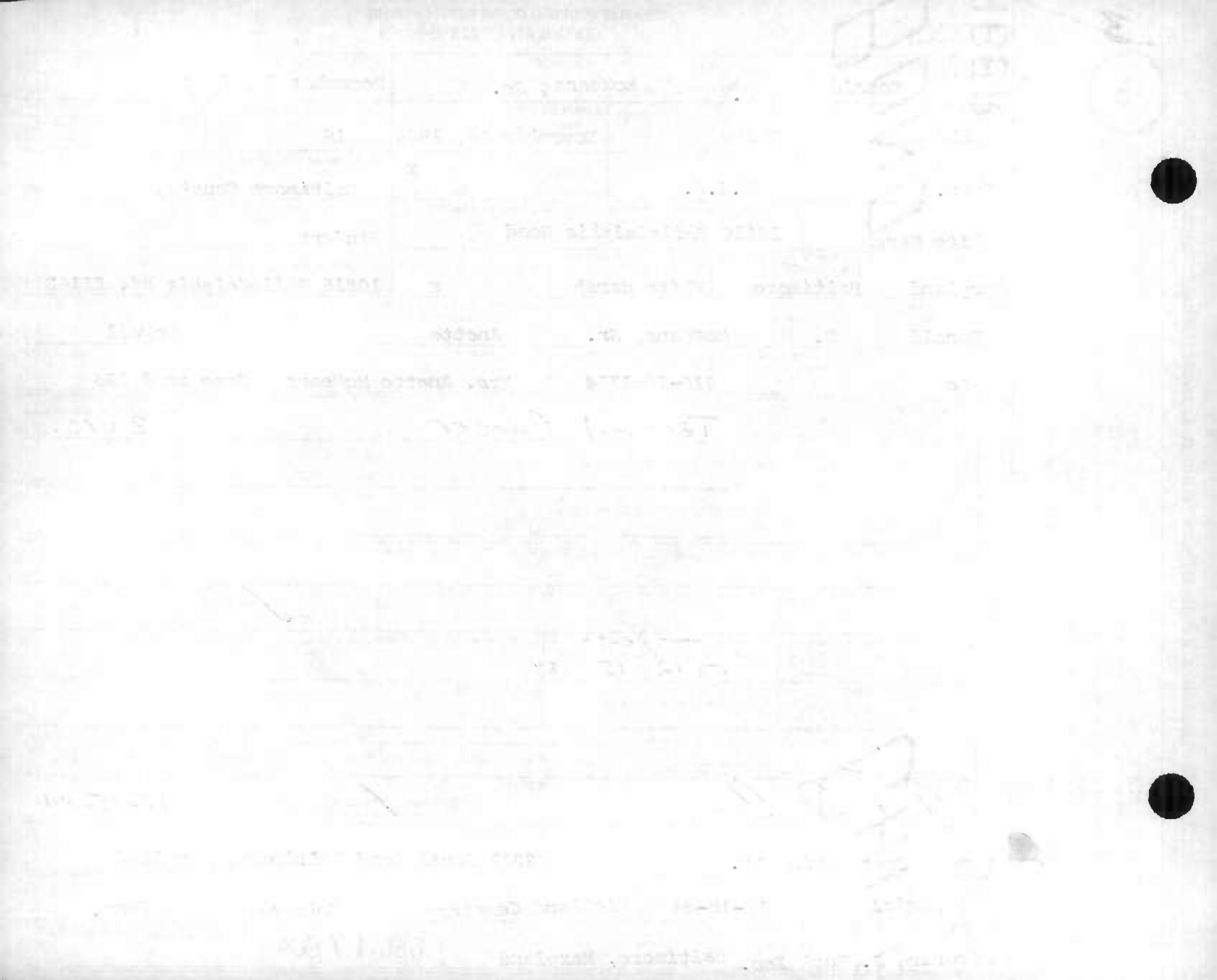
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32250 3 2 2 5	
1. DECEASED NAME (TYPE OR PRINT) EVELYN M McMANUS			20. DATE OF DEATH MONTH 12 DAY 31 YEAR 84 TIME 8:00 PM		
2. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 26 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. CITY OR TOWN Westminster		13c. STREET ADDRESS / ZIP CODE 412 Poole 21157	
14. FATHER'S NAME FIRST Walter MIDDLE Wilhelm LAST Wilhelm		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Florence LAST Florence			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-03-6144		17. INFORMANT ADDRESS Mrs. Pat Tidman 5319 Wendy Road 21784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RECURRENT PNEUMOTHORAX DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRONCHITIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ---					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-23-84 to 12-31-84 , that (I) (we) last saw the deceased alive on 12-31-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Shaf		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAF		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/85		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery	
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. ADDRESS 3818 Roland Avenue 21211		23d. LOCATION CITY OR TOWN Rayville COUNTY Maryland		25. DATE RECEIVED BY REGISTRAR JAN 2 1985	

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1. DECEASED NAME		2a. DATE OF DEATH		2b. HOUR	
FIRST	MIDDLE	MONTH	DAY	YEAR	
Ronald D. McMeans, Jr.		December 15, 1984		M	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		November 26, 1968	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Penn.		U.S.A.		Baltimore City or County of DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION	
White Marsh		10816 Philadelphia Road		Student	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		White Marsh	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Ronald D. McMeans, Sr.		Anette McNeil		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
810-10-1774		Mrs. Anette McMeans		Same as # 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Terminal Cancer					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		P.M. 12 15 1984		[ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2]	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Curt D. Civin		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12-15-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Curt Civin MD.		2217 South Road Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12-18-84		Richland Cemetery	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Johnstown		Penn.		COUNTY STATE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		DEC 17 1984		John Davidson	
Leonard J. Ruck Inc. Baltimore, Maryland					

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 3 2
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary Margaret MEADOWCROFT			2a. DATE OF DEATH MONTH DAY YEAR Dec. 31, 1984		2b. HOUR 5:00AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb 13, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Fullerton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4230 Necker Ave. 21236		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Fullerton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael J. Quinn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia M. Burke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Baltimore, Md. 21236 Edwin Meadowcroft 4230 Necker Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of tongue, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION 2		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-8-84</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>11-8-84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William C. Gray, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED Jan 2, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Gray, M.D.		22e. ADDRESS University Hospital Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR NAME Doppel Funeral Homes, Inc.		ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR JAN 2 1985	
25b. REGISTRAR'S SIGNATURE <u>James Davidson-Randall</u>					

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

BP

RECEIVED

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DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR <i>Goldie B.</i>		3 2 2 3 3 REG. NO.		1. DECEASED NAME (TYPE OR PRINT) <i>Goldie B. Medtart</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12 1 84</i>		2b. HOUR <i>1:30 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 19 03</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Towson, Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Joseph's Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Towson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>7001 N. Charles St. 21204</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Fitch</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Rheb</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-74-3886</i>		17. INFORMANT ADDRESS <i>Cockeysville, Md. Dorothy E. Heinz 611 Cranbrook Rd. 21030</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/1</i> , 19 <i>84</i> , to <i>12/1</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>12/1</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>David Klassen</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>12/1/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID KLASSEN</i>				22e. ADDRESS <i>ST JOSEPH'S HOSP. BALTIMORE MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 5, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld Home</i>				ADDRESS <i>6500 York Rd. 21212</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 04 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John F. ...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

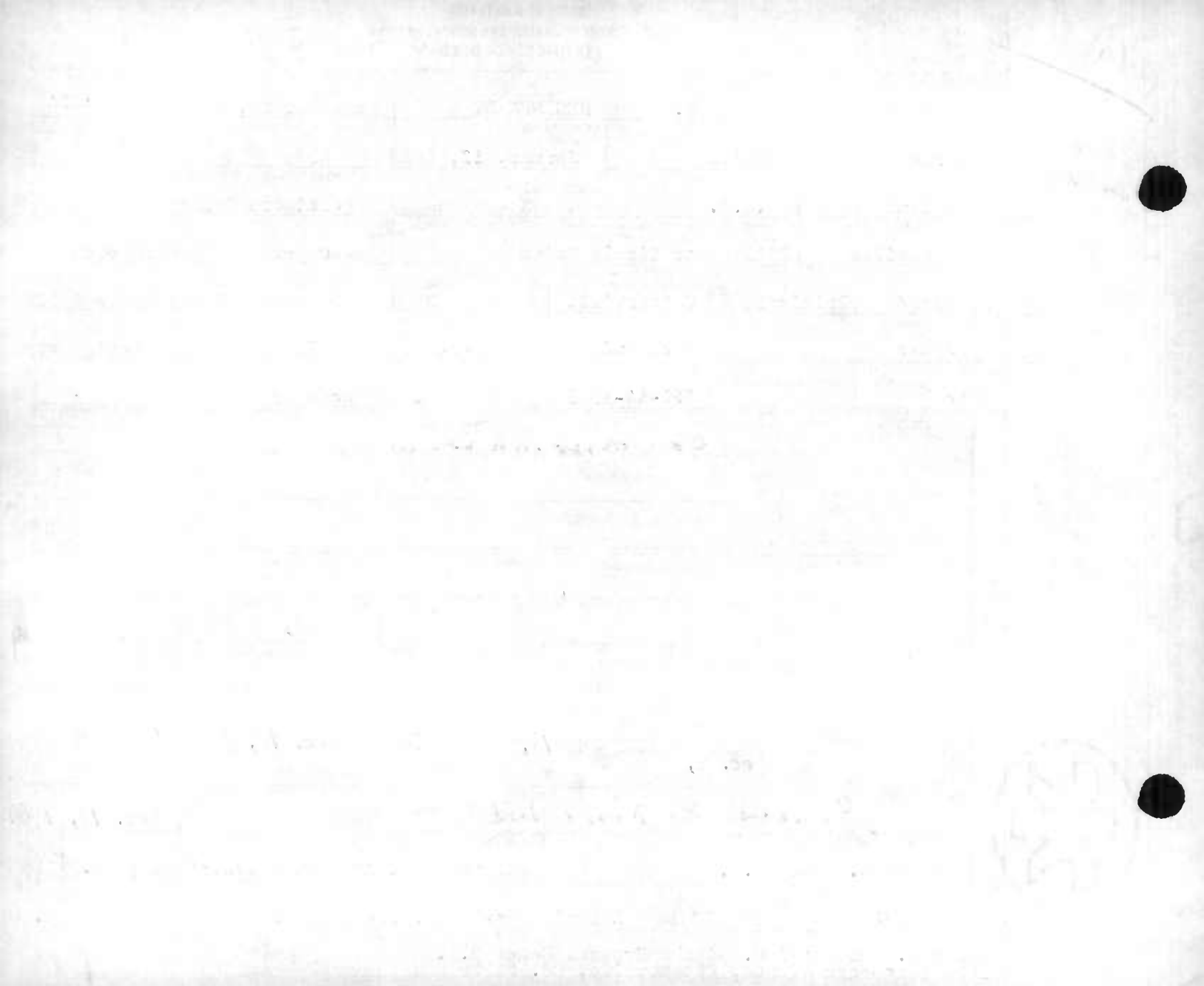
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) ESTHER R. MEGENHARDT					2a. DATE OF DEATH MONTH DAY YEAR December 10, 1984			2b. HOUR 11:35A_M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 12, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2121 Cedar Circle Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2121 Cedar Circle Drive 21228	
14. FATHER'S NAME FIRST MIDDLE LAST James Richmond					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael Ellen Montgomery					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-1535		17. INFORMANT Marian Dore		ADDRESS Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from May 14, 1976 to Dec. 10, 1984 that (I) (we) lost saw the deceased alive on Dec. 9, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James E. Rowe M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Dec. 11, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Rowe M.D.				22e. ADDRESS 413 Commonwealth Avenue, Baltimore, Md. 21228						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 12/13/84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION CITY OR TOWN COUNTY Woodlawn Wendell Md.				
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke				25a. DATE RECD. BY REGISTRAR 1984						
24b. ADDRESS 1630 Edmondson Avenue, Catonsville, Md. 21228				25b. REGISTRAR'S SIGNATURE						



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 3 5
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
NATHAN						MELTZER		12		5	87	10:15 M		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YEAR		
MALE		WHITE		NOVEMBER 1, 1905				79		YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH						
NEW YORK		U.S.A.						BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH XX BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY				
		2302 VELVET VALLEY WAY 21117						PROPRIETOR		Advertising Agency				
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MARYLAND				BALTIMORE		OWINGS MILLS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2302 VELVET VALLEY WAY 21117				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS						
ABRAHAM				MELTZER				BESSIE				8 HODES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT								
NO				074-09-4246		1909 E. FAYETTE ST. SYRACUSE, N.Y. 13210 BIRNBAUM FUNERAL SERVICE, INC.								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) METASTASIS		5 MJS	
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10 19 84, to 13 19 84, that (I) (we) last saw the deceased alive on 19 04, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I) (did not) see the body after death.		22b. SIGNATURE ERIC KOWINSKY		22c. DATE SIGNED 12-6-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
ERIC KOWINSKY		JOHNS HOPKINS HOSPITAL					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
REMOVAL-BURIAL		12/7/84		TEMPLE ADATH YESHURUN CEM		SYRACUSE NEW YORK	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOLLEVIN SON & BROS., INC.		DEC 7 1984		[Signature]			
6010 REISTERSTOWN RD., BALTIMORE, MARYLAND 21215							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked at item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

RECEIVED
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 3 6
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <u>Dorothea - Mentzer</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>12/13/84</u>				2b. HOUR <u>0125M</u>	
3 SEX <u>Female</u>		4 RACE <u>WHITE</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>10 23 08</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE COUNTY</u> MD.			
10. CITY OR TOWN OF DEATH <u>BALTO. COUNTY</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BALTIMORE COUNTY GENERAL HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>BARMAID</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>WILSON'S</u>	
13a. STATE <u>MARYLAND</u>				13b. CITY OR TOWN <u>BALTIMORE</u>		13c. STREET ADDRESS / ZIP CODE <u>21113</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>Edward Mentzer</u>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Jeanette Jones</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>217-20-6169</u>		17 INFORMANT ADDRESS <u>Margaret Gilman 4703 Mawani Rd. 21206</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-7</u> 19 <u>82</u> to <u>12-13</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-12</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12-13-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>POTANIMAL MD</u>				22e. ADDRESS <u>5400 OLD COURT RD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-15-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>			
24 FUNERAL DIRECTOR NAME <u>Lorraine Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 17 1984</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

BALTIMORE COUNTY

CHARTER

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

1971

1971

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

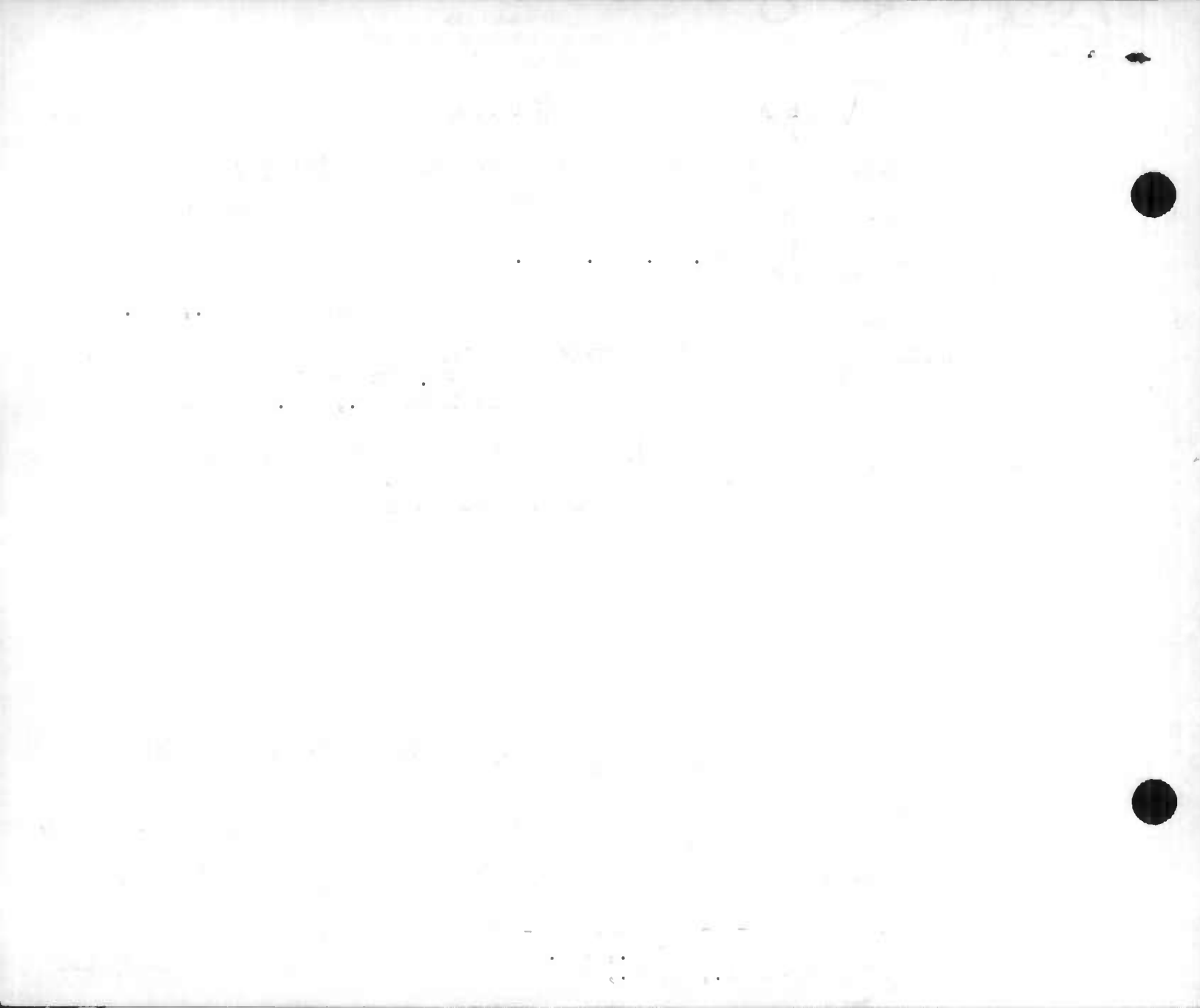
OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

OFFICE OF THE BALTIMORE COUNTY COMMISSIONER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 3 7
REG. NO.

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST VERA MERKIN		2a. DATE OF DEATH MONTH DAY YEAR 12 10 84		2b. HOUR 1:30 A.M.	
3. SEX F. FEMALE		4. RACE 1 WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 14 25		6. AGE (IN YEARS LAST BIRTHDAY) 59 yrs		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
11. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. CITY OR TOWN MARYLAND		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 3615 CLARKS LA., APT. 408 #21215			
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL GOROCHOVSKY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT MR. ARON MERKIN 3615 CLARKS LA., APT. 408 #21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - chr Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 17a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-83</u> to <u>12-10</u> , 19 <u>84</u> , that (I) (we) lost <u>12-10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Govindaraj Govindaraj</u>		DEGREE M.D. - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-10-84					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) RAYADUR G. GOVINDARAJ		22e. ADDRESS Balt County Gen Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-11-84		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON-CHIZUK AMUNO		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE <u>Davidson-Rendall</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 3 8
REG. NO.

2011
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM EDWARD MESSICK			2a. DATE OF DEATH MONTH DAY YEAR December 31, 1984		2b. HOUR 4:00 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 30, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1524 Forest Park Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Security-Federal.		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leon Messick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Bostick		13e. STREET ADDRESS / ZIP CODE 1524 Forest Park Avenue 21207			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT Virginia B. Messick		ADDRESS Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA TUSIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA - PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/15/84 12/30/83
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-15-85 , 19 85 , to 12-31 , 19 84 , that (I) (we) last saw the deceased alive on 12-15 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Norman Kleiman MD				DEGREE MD		22c. DATE SIGNED 12/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman Kleiman M.D.				22e. ADDRESS 3803 Edmondson Ave Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/2/1985		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR JAN 2 1985			
				25b. REGISTRAR'S SIGNATURE F. Davidson Randall			

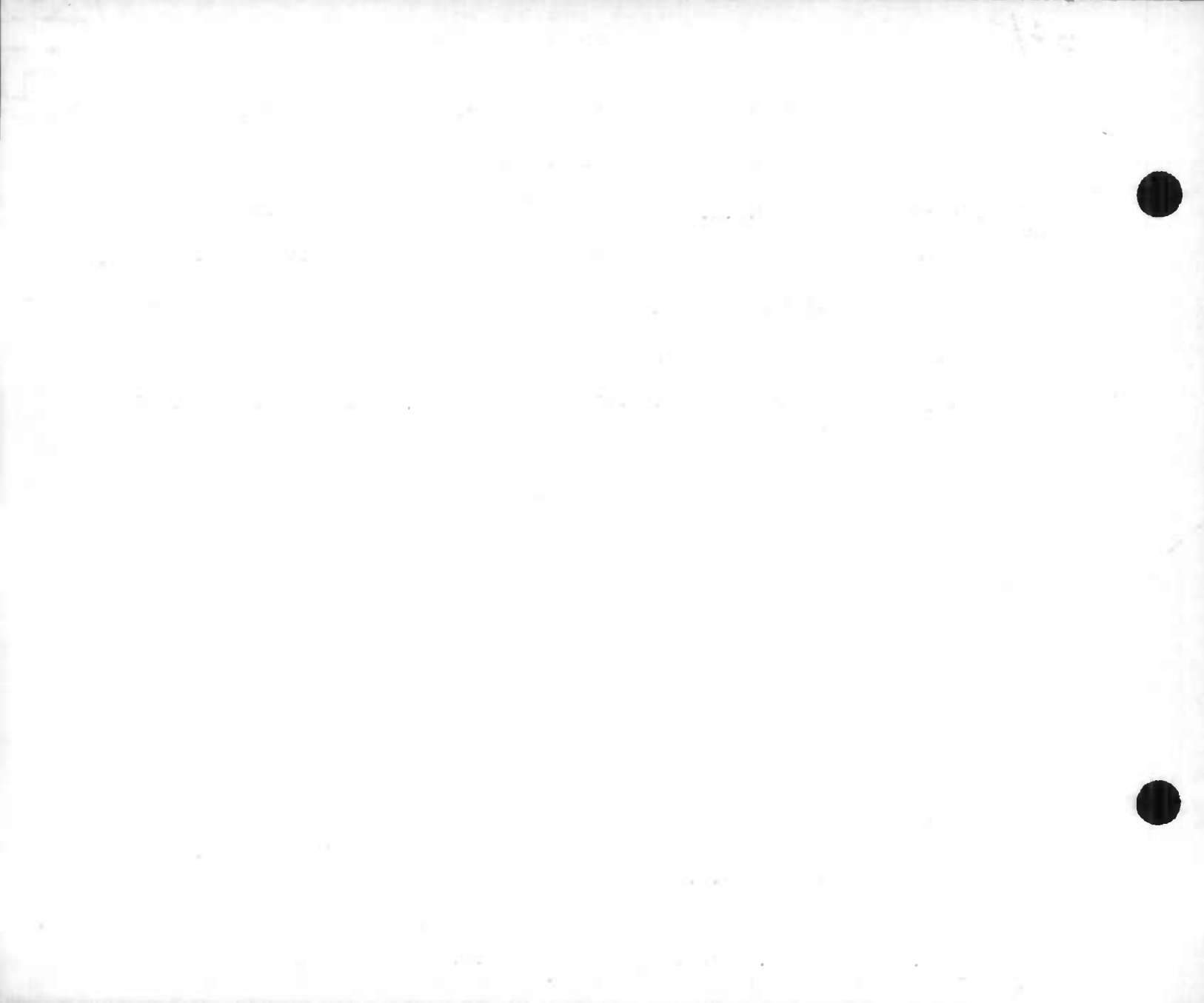
MEDICAL CERTIFICATION

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

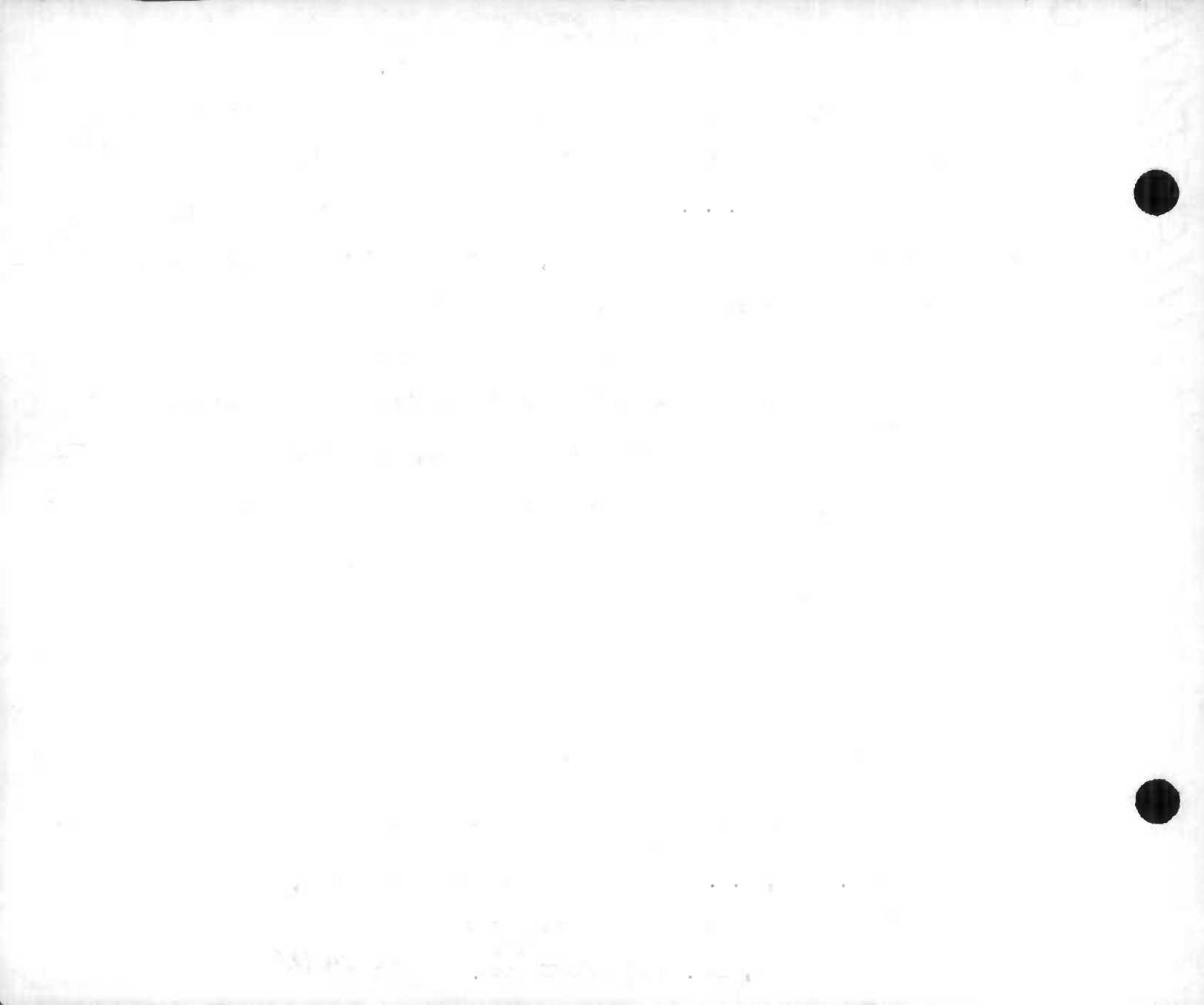
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 3 9
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
RAYMOND JOHN MEUSE			12 21 84			M		
3. SEX			4. RACE			5. DATE OF BIRTH		
MALE			WHITE			1 13 10		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
Canada			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Arbutus			5609 OAKLAND ROAD, 21227			Truck Driver		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
Maryland			Baltimore			5609 Oakland Road 21227		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
John			Meuse			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
WW II			Denise Dailey			5609 Oakland Rd. 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>Cardiac Arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Atherosclerotic Cardiovascular Disease 5 years</i>								
DUE TO, OR AS A CONSEQUENCE OF <i>(c)</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Thoracic Aneurysm and Aortic Insufficiency</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on <i>Sept 12</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
<i>Jeffrey F. Cole, M.D.</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>12/21/84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
JEFFREY F. COLE, M.D.						3455 WILKENS AVENUE, 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			12/24/84		Woodlawn Cemetery		City or Town County State	
							Woodlawn Baltimore Md	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229						DEC 24 1984		<i>John Hubbard</i>

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (HOSPITAL USE ONLY) should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, it must be signed by a physician, nurse, or other qualified person.

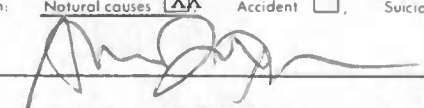
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 4 0			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie Bounds Mewshaw							2a. DATE OF DEATH MONTH DAY YEAR December 5, 1984		2b. HOUR 8 50 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1921		6. AGE (IN YEARS (LAST BIRTHDAY)) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dorchester Co., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6925 A Lachlin Circle-Glenmount Apt.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Educator		12b. KIND OF BUSINESS OR INDUSTRY AA County					
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 400 Noble Street		21643			
14. FATHER'S NAME FIRST MIDDLE LAST Irving Bounds				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Ferguson				ADDRESS Baltimore, MD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-36-9290		17. INFORMANT Robert Mewshaw, 6925 A Lachlin Circle									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Adult onset Diabetes mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs 9-10 yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) History of Cancer of the colon													
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 12-7-83 , 19 83 , to 12-5 , 19 84 , that (2) (we) lost saw the deceased alive on 11-14 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (that) (I) (did) (did not) see the body after death.													
22b. SIGNATURE Mike Fadden				DEGREE MD				22c. DATE SIGNED 12/5/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mike Fadden, M. D.				22e. ADDRESS 302 Collins Avenue, Hurlock, MD 21643									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD							
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR DEC 7 1984		25b. REGISTRAR'S SIGNATURE Gina Davidson-Randall							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 2 4 1

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 26 1984										2b. HOUR M 5:17 a M			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN A. MICHAEL, JR.												2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 26 1984		2d. HOUR a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 29 24		6. AGE (IN YEARS) (LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 26 1984		7d. HOUR a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver				12b. KIND OF BUSINESS OR INDUSTRY Trucking			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE CITY COUNTY Md. Carroll Hampstead												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3205 Laverne Circle 21074	
14. FATHER'S NAME FIRST MIDDLE LAST John A. Michael, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Richards									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Army		17. INFORMANT ADDRESS Md. Mrs. Sophie Michael, Hampstead									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 12-27-84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-29-84		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.					
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.						25a. DATE REC'D. BY REGISTRAR DEC 28 1984								25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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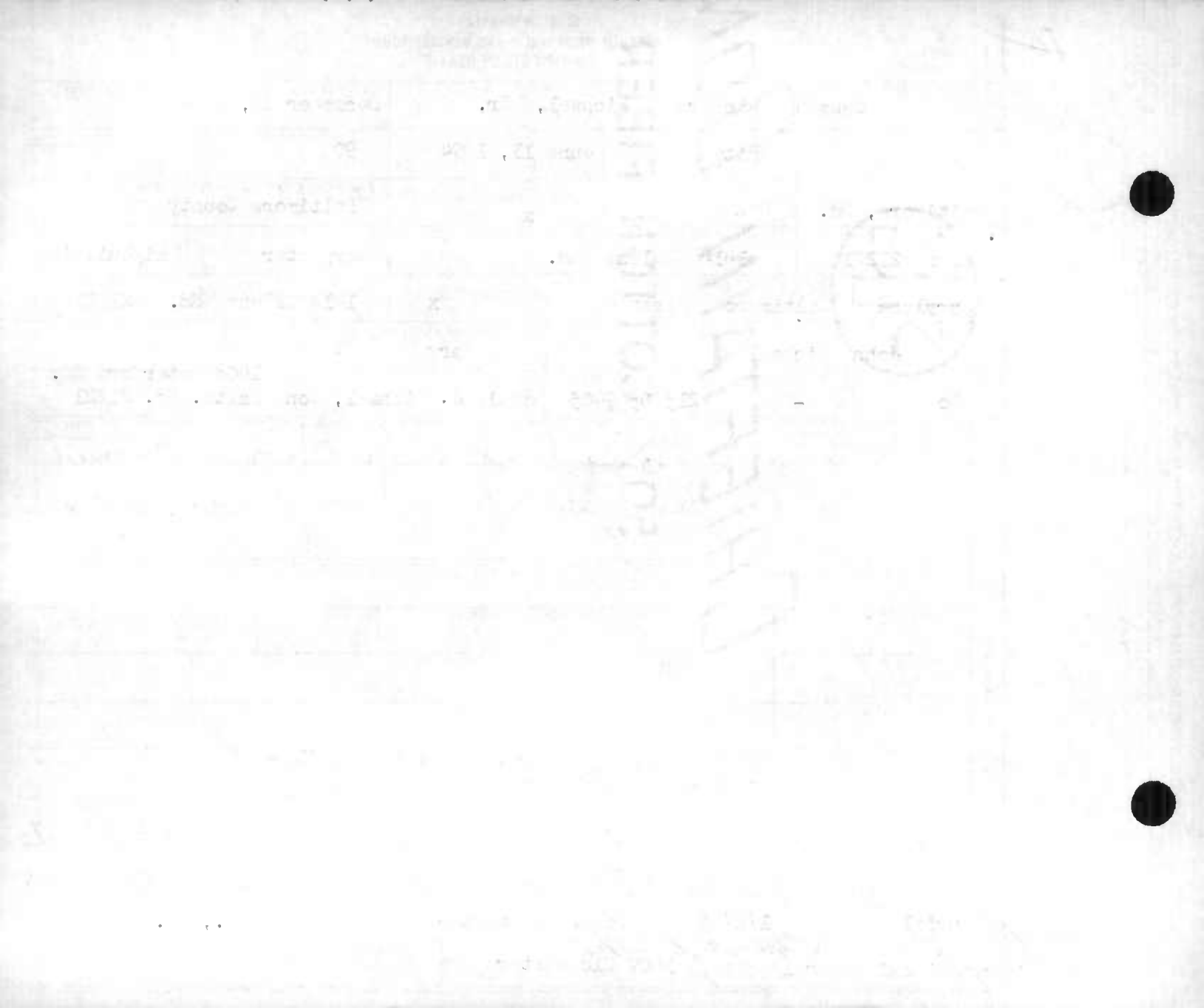
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 4 2 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Oswald Richard Michael, Sr.						2a. DATE OF DEATH MONTH DAY YEAR December 29, 1984		2b. HOUR M	
1. SEX Male		4. RACE White		5. DATE OF BIRTH DAY MONTH YEAR June 11, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
1. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Essex 21221		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1414 Galena Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Shipbuilding			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY Baltimore 13c. CITY OR TOWN Essex				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1414 Galena Rd. 21221					
14. FATHER'S NAME FIRST MIDDLE LAST John Michael				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 05 9405		17. INFORMANT ADDRESS 1408 Waterford Rd. Balto. Md. 21221 Edwin J. Michael, Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic coronary vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 80 to 12/29 84 that (I) (we) lost saw the deceased alive on 12/22 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Louis J. Simonoff				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/31/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS SIMONOFF				22e. ADDRESS 2108 CRENS RD BALT MD 21226							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/2/85		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.					
24. FUNERAL HOME Pradizinski Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 2 1985				25b. REGISTRAR'S SIGNATURE [Signature]			

BP



FOR 1/11/85 rja
1. STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sabina M. Miller			2a. DATE OF DEATH MONTH DAY YEAR 12 25 84		2b. HOUR 3 05 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 21 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS Hospice		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H/W	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN EDGEMERE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 6909 N. P+ RD. 21219
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY UNK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. DATE OF DISCHARGE (IF YES, GIVE WAR OR DATES) 215-24-1877 800-02-1846		17. INFORMANT ADDRESS ANTHONY MILLER 6909 N. P+ RD. 21219	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from December 1, 1984, to December 25, 1984, that (I) (we) lost saw the deceased alive on December 25, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE M. Faulkner MD				23b. DATE SIGNED	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) M. Faulkner				23d. ADDRESS STELLA MARIS Hospice	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/29/84	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.
24. FUNERAL DIRECTOR NAME ADDRESS CONNELLY FUNERAL HOME OF DUNDALK			25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Linda M. Davidson

MEDICAL CERTIFICATION

23a. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

23b. DATE SIGNED

23c. PHYSICIAN'S NAME (TYPE OR PRINT)

23d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

1

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the County of Santa Fe, New Mexico, this 1st day of January, 1912.

JOHN J. HARRIS, Sheriff

Subscribed and sworn to before me this 1st day of January, 1912.

Notary Public for Santa Fe County, N.M.

Witness my hand and the seal of the County of Santa Fe, New Mexico, this 1st day of January, 1912.

JOHN J. HARRIS, Sheriff

DHMH - 16 60M 7/84
(VRA 15. 4)

[illegible]

[illegible]

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 2 4 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MARY PATRICIA MIHALIK						2a. DATE KNOWN OF DEATH ESTIMATED 12 1 84		2b. HOUR 1000 M							
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/4/34		6. AGE 50 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. DATE PRONOUNCED DEAD 12 1 84		9. HOUR 1125 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Dundalk				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7120 Railway Ave. 21222				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7120 Railway Ave. 21222					
14. FATHER'S NAME James L. Sadler						15. MOTHER'S MAIDEN NAME Margaret Ege									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 212-36-5492		17. INFORMANT John Mihalik 7120 Railway Ave. 21222									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast with multiple metastases</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE J. Crossan O'Donovan				M.D. Deputy				DATE SIGNED 12/1/84							
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN				ADDRESS 2112 DUNDALK AVE, BALT., MD. 21222											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/5/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.							
24. FUNERAL DIRECTOR NAME Connelly Funeral Home of Dundalk						25a. DATE REC'D. BY REGISTRAR DEC 4 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall							



WEEKLY REPORT

REPORT OF THE

Commission of the

General

479110170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified and signed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 2 2 4 6 REG. NO.		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST		MIDDLE		LAST		MONTH		DAY YEAR	
Harold A. MILLER						December 24, 1984		5:28 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Male		White		MONTH DAY YEAR		69 YRS		MONTHS DAYS HOURS MIN.	
July 26, 1915									
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.				Baltimore County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rossville 21237		Franklin Square Hospital		Mechanic		Shet Metal Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		Baltimore		Essex 21221		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		318 Torner Road 21221	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Yes <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		232 07 7905		Nola R. Miller (Wife)	
Arthur B. Miller		Emma Wolfe		WW II				Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Malnutrition</u>					
				DUE TO, OR AS A CONSEQUENCE OF (c)					
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 23, 1984</u> to <u>December 24, 1984</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>December 24, 1984</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Richard Haber				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12-24-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Richard Haber, M. D.		9000 Franklin Square Drive, 21237		Burial		12/28/84		Holly Hill Memorial	
23d. FUNERAL HOME (NAME AND ADDRESS)		23e. DATE REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		23g. DATE REC'D BY REGISTRAR		23h. REGISTRAR'S SIGNATURE	
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.		DEC 27 1984		John Davidson-Randall					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 4 7
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Marion H. Miller			2a. DATE OF DEATH MONTH DAY YEAR December 2, 1984		2b. HOUR 3 A.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 29, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 81 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maynard, Mass.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7 Osborne Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Gordon L. Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sophia Stuart		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-46-3264		17 INFORMANT Mrs. Ruth Ann Lentz-7 Osborne Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Brain metastases DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of lung					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Sp valve replacement surgery & anticoagulant Rx. Candidiasis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 19 84 , to December 19 84 , that (I) (we) lost saw the deceased alive on 11/18 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kathleen Dickerson		DEGREE MD		22c. DATE SIGNED 12/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/84		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery - Cambridge, Mass.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR DEC 3 1984			
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P. A.		25. REGISTRAR'S SIGNATURE na wildson-hendell			
736 Edmondson Ave., Catonsville, Md. 21228.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

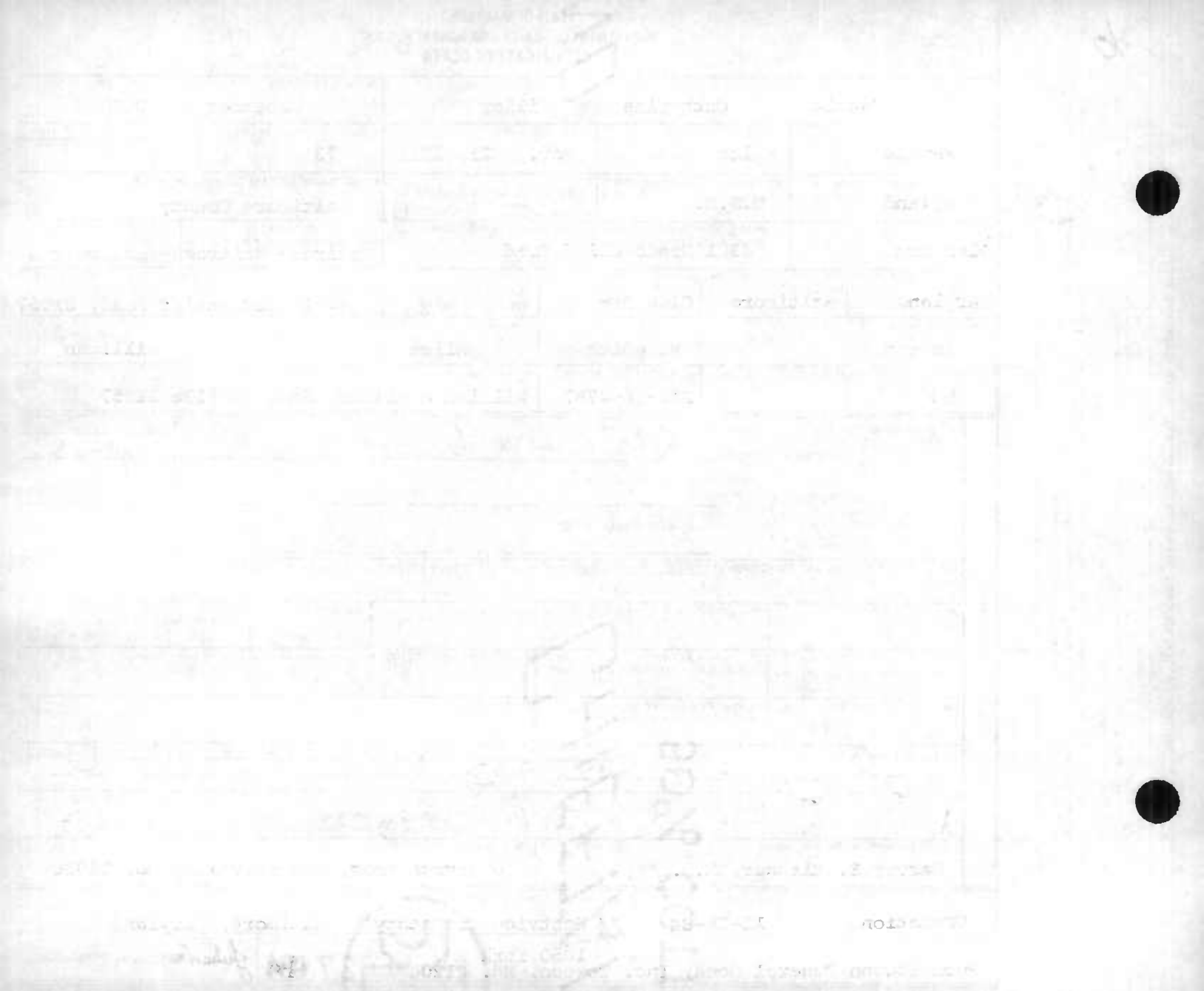
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 2 4 8	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Mattie Catherine Miller						2a. DATE OF DEATH MONTH December DAY 25 YEAR 1984		2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Nov. DAY 21 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Glen Arm		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4301 Meadowcliff Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Waitress		12b. KIND OF BUSINESS OR INDUSTRY Haussner's			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Glen Arm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4301 Meadowcliff Road, 21057			
14. FATHER'S NAME FIRST Roscoe MIDDLE LAST Meredith				15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE LAST Milligan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-26-4787		17. INFORMANT ADDRESS William H Miller, Same As #13e 21057							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-15 19 84 to 12-18 19 84 , that (I) (we) lost 12-18 19 84 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12-26-84	
22b. SIGNATURE X Harvey S. Mishner, M.D. PA		DEGREE MD PA		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harvey S. Mishner, M.D. PA				22e. ADDRESS 10 Warren Road, Cockeysville, Md. 21030							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-26-84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE 					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 3 2 2 4 9	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RACHEL LENA MILLER										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 19 84	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 03 22		6. AGE (IN YEARS) (LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH DAKOTA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH ARBUTUS		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1134 Gloria Ave. 21227						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR FOR INFORMATION		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN ARBUTUS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1134 GLORIA AVENUE, 21227			
14. FATHER'S NAME FIRST MIDDLE LAST JACOB W. SCHMIDT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MARIE UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 502-16-0303		17. INFORMANT ADDRESS 21227 REV. JAMES D. MILLER, JR. 1134 GLORIA AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-19-84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-22-84		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE 			

DHMH - 17
(VR A15 ME (5))

EDGE COUNTRY

CHATELAIN

WIND



FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 5 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret M. MITCHELL			2a. DATE OF DEATH MONTH DAY YEAR December 3, 1984			2b. HOUR 7:40P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 24 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6829 Holabird Ave. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Kessler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Biedenbeck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 218-22-4126		17. INFORMANT ADDRESS Bertha L. Dietrich Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 2, 1984 , to December 3, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 3, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Risa Davis</i> MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Risa Davis						22e. ADDRESS 9000 Franklin Square Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/6/1984		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR DEC 5 1984				

The medical certificate must be notified at once.

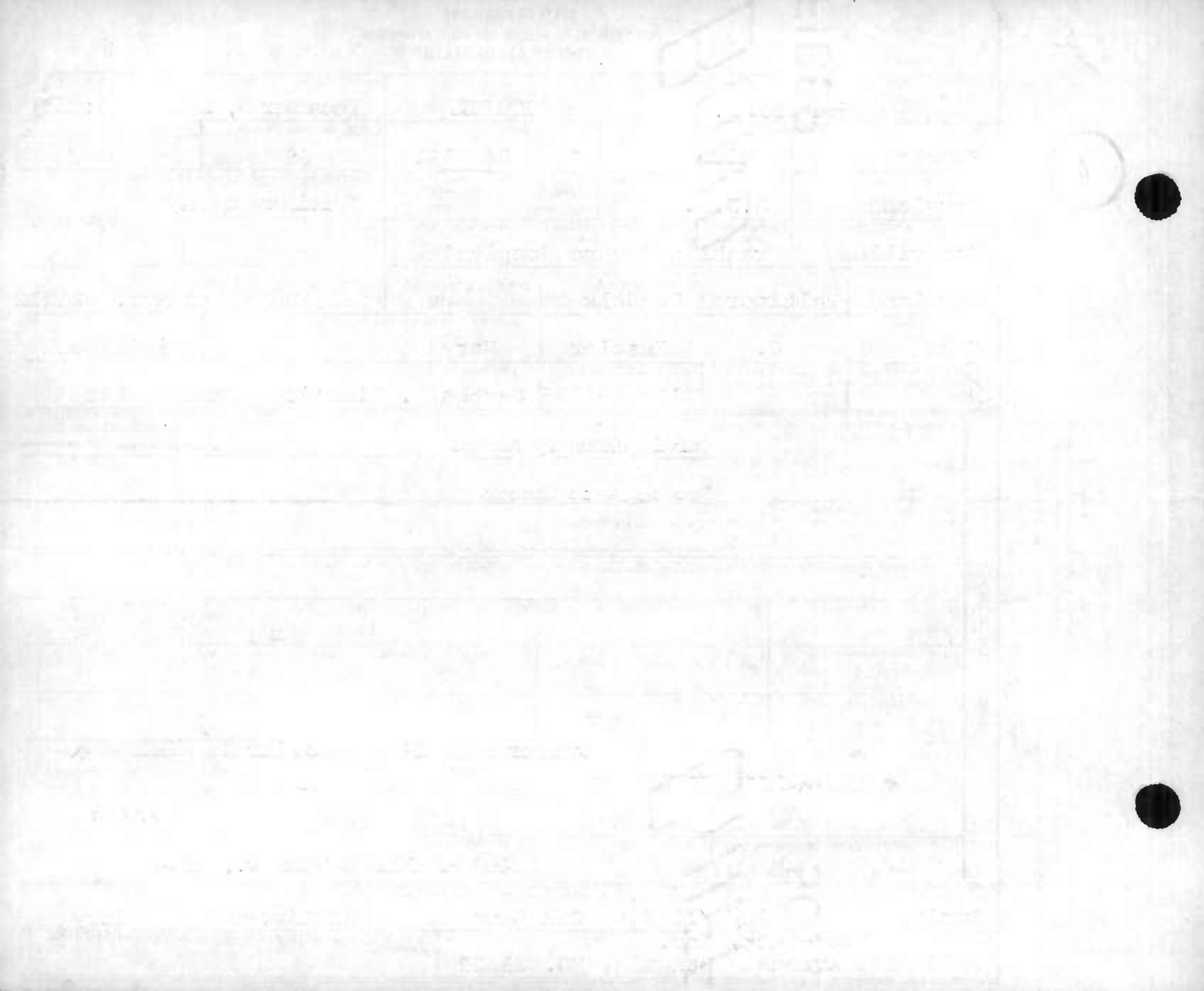
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed without 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, it is not an injury, or other traumatic event, or medical examiner's office notified advance.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 5 1
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CHARLES D. MOHRY		2a DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1984		2b HOUR P MIN. 9:30	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR JUNE 9, 1901		6 AGE (IN YEARS LAST BIRTHDAY) YRS 83	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10 CITY OR TOWN OF DEATH PARKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7843 BAGLEY AVE.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MTG. OF S&P	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY DELTA CITY OR TOWN DELTA		13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c STREET ADDRESS / ZIP CODE R. RT. 3 21314	
14 FATHER'S NAME FIRST Unknown MIDDLE Unknown LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown			

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. 215 03 3558	17. INFORMANT FAMILY RECORDS
---	---	--

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA of RECTUM DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MONTHS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a DATE OF OPERATION DEC 13, 1984	19b CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA of RECTUM	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (the hospital) attended the deceased from **ABOUT JUNE 19, 83** to **DEC 13, 1984**, that (I) ~~last~~ saw the deceased alive on **DEC 13, 1984**, and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~was~~ (did not) view the body after death.

22b. SIGNATURE John G. Lavin MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-29-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN G. LAVIN		22e. ADDRESS 6805 YORK ROAD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b DATE DEC 29, 1984	23c NAME OF CEMETERY OR CREMATORY GRESHAM MOUNT	23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24 FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES HARFORD RD.		25a DATE REC'D. BY REGISTRAR DEC 31 1984	25b REGISTRAR'S SIGNATURE [Signature]



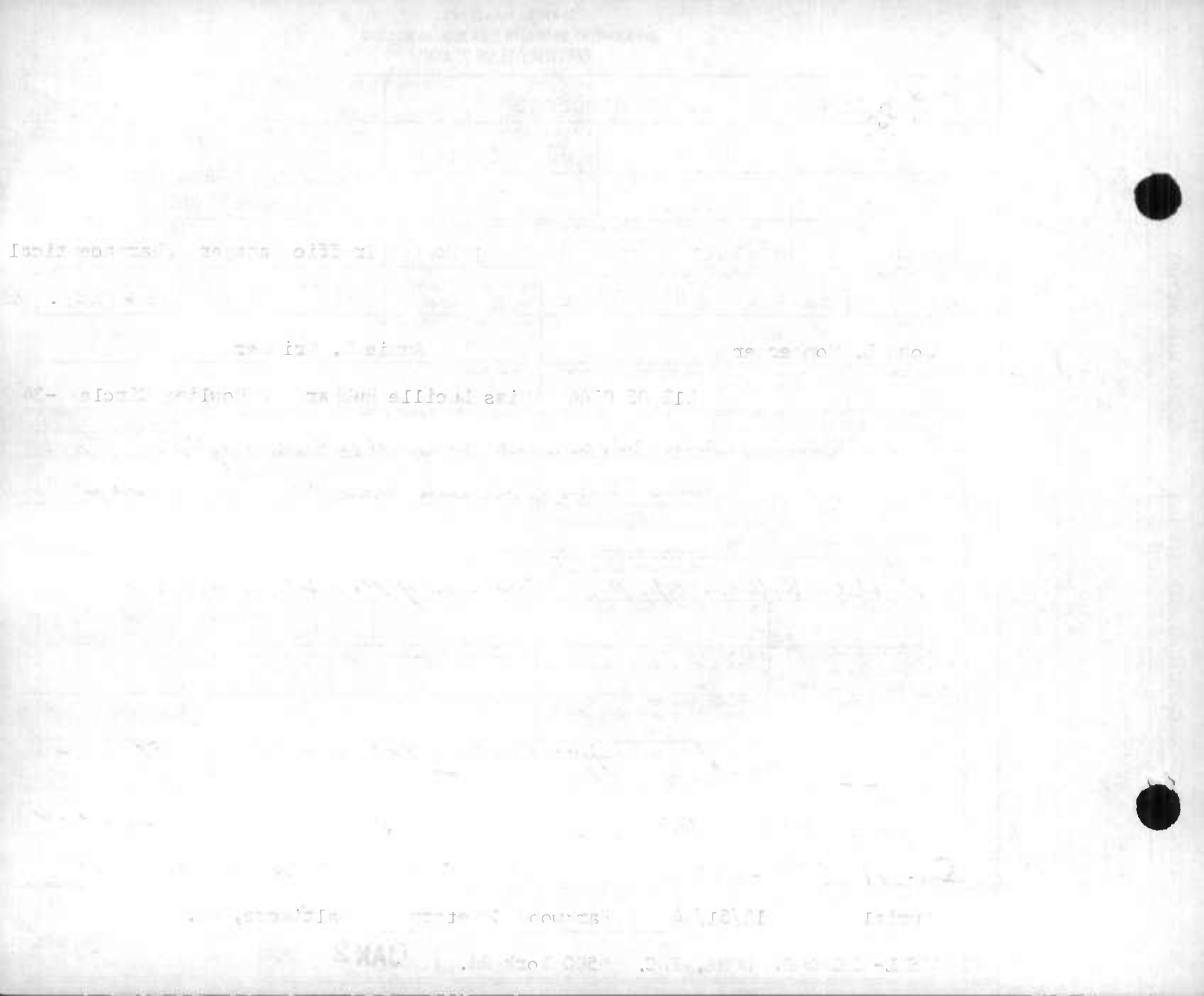
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 2 5 2	
1. DECEASED NAME (TYPE OR PRINT) John L. Momberger						2a. DATE OF DEATH MONTH DAY YEAR 12-28-84		2b. HOUR 3:30P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 22 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Traffic Manager		12b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1659 East Northern Pkwy. 21239			
14. FATHER'S NAME FIRST MIDDLE LAST John L. Momberger						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie L. Trimmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212 03 0744		17. INFORMANT ADDRESS Miss Lucille Hubbard 6 Dowling Circle -34							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with left ventricular dysfunction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 20 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus type II, Concision of Prostate 5 months											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from June 1963 , 19 1963 , to Dec 28 , 19 84 , that (I) (we) last saw the deceased alive on Dec 28 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samuel O'Mansky M.D.		DEGREE						22c. DATE SIGNED Dec 29/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel O'Mansky		22e. ADDRESS 8405A LOCH RAVEN BLVD. 21204									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.						25a. DATE REC'D BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 2 5 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Gertrude Petersen Money				December 1, 1984		1245 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		Feb. 2, 1892		92 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New York		U.S.A.				Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
		Masonic Home - Bonnie Blink		Homemaker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore		Dundalk		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
Neils P. Petersen		Sarah Schweitzer		NO		213-20-9310	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from _____, 19____, to <u>12/1/84</u> that (we) last saw the deceased alive on _____, 19____, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE		22c. DATE SIGNED	
John W. Bowie, MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/1/84	
22d. ADDRESS				22e. ADDRESS			
John Bowie, MD				824 Stagshead Road Towson, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/5/1984		Rosedale Cemetery		Orange, New Jersey	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Walter Brooks Bradley, Inc. Dundalk, MD 21222				DEC 3 1984		June Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO. 3 2 2 5 4

1. DECEASED NAME (TYPE OR PRINT) Mr. James V. Montgomery Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 28 1984			2b. HOUR M AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 6 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5505 Pembroke Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Acme Markets		12b. KIND OF BUSINESS OR INDUSTRY retired	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5505 Pembroke Ave. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Leo Harmon Montgomery				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine L. Welsh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT Mrs. Rita Montgomery		ADDRESS 5505 Pembroke Ave. Woodlawn Maryland		21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe bronchitis and emphysema								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Coronary Heart Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8630 Liberty Plaza Mall Randallstown, Md. 21133					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above, if true) (did) (did not) view the body after death.									
22b. SIGNATURE Jerome H. Ginsberg				DEGREE M. D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-29-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerome H. Ginsberg, M. D.				22e. ADDRESS 8630 Liberty Plaza Mall Randallstown, Md. 21133					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 31 1984			
ADDRESS 8728 Liberty Road Randallstown, Maryland 21133						REGISTRAR'S SIGNATURE [Signature]			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 5 5
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Robert L Morant</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12 5 1984</u>		2b. HOUR <u>3:53 PM</u>
3. SEX <u>male</u>	4. RACE <u>BLACK</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>09 01 1937</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>47</u> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Randallstown</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore County General</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>Maryland</u>		13b. CITY OR TOWN <u>Randallstown</u>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <u>3907 Bonner Rd 21216</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Dewitt Morant</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Alethia Morant</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>216-30-6807</u>		17. INFORMANT ADDRESS <u>Alethia Morant 3907 Bonner Rd 21216</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic shock.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>klebsiella pneumoniae</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetic ketoacidosis.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>84</u> , to <u>12/5</u> , 19 <u>84</u> , that (I) (we) just saw the deceased alive on <u>12/5/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Allen J. Chiriacus M.D.</u>				22c. DATE SIGNED <u>12-5</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen J. Chiriacus M.D.</u>				22e. ADDRESS <u>32-k Stockmill Rd 21208</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-10-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brooklyn A.A Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 12 1984</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Chas.A. Rice FSPA 1300 Eutaw Place</u>				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

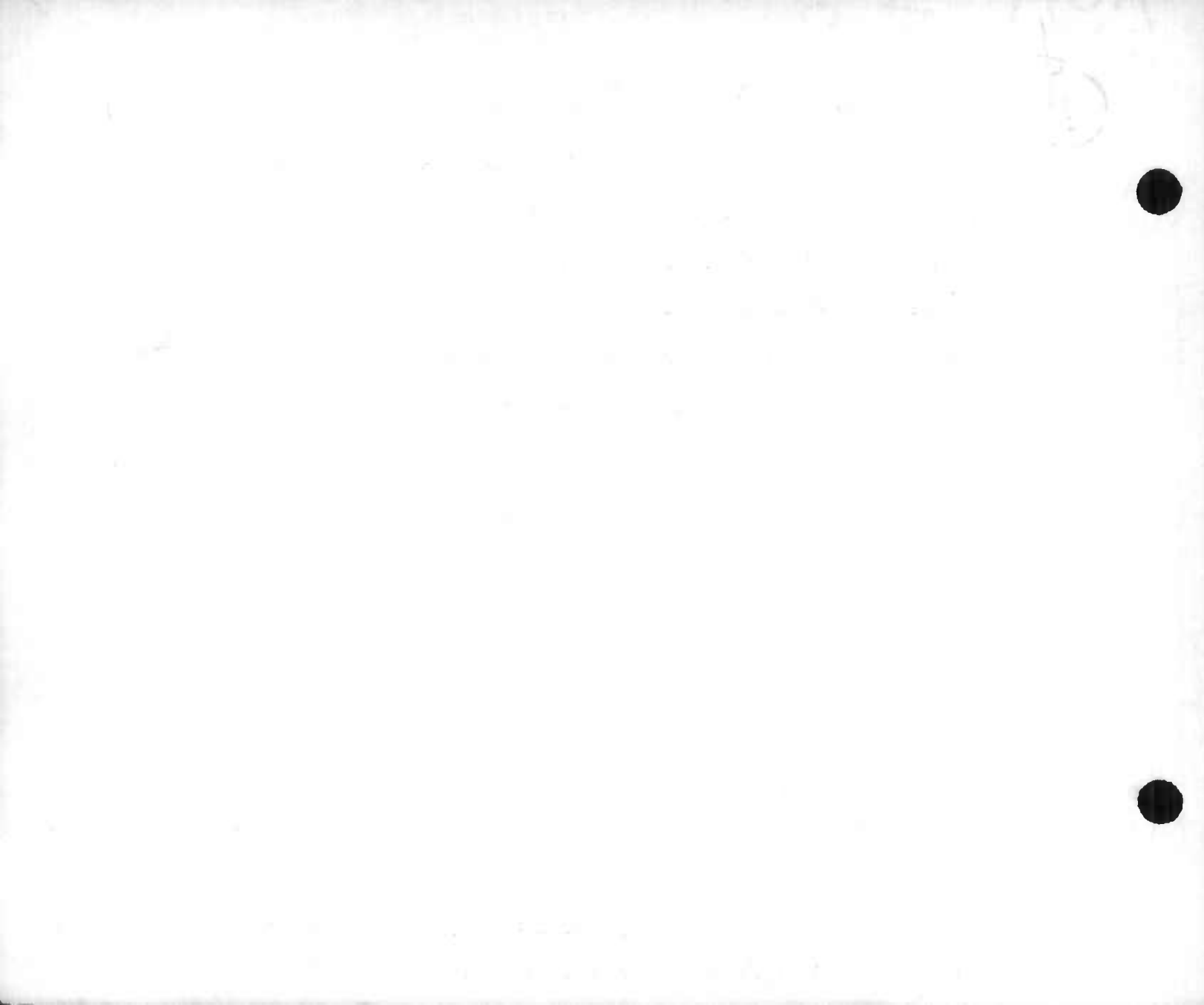


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 5 6 REG. NO.			
1 - FOR REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Naomi</u> MIDDLE <u>Ruth</u> LAST <u>Morena</u> <u>NAOMI RUTH MORENA</u>						2a. DATE OF DEATH MONTH <u>12</u> DAY <u>2</u> YEAR <u>84</u>		2b. HOUR <u>1230 A.M.</u>			
3. SEX <u>Female</u>		4. RACE <u>Caucasin</u>		5. DATE OF BIRTH MONTH <u>10</u> DAY <u>18</u> YEAR <u>11</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		8. IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.							
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore County Gen. Hosp.</u>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Dietician</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Private Inst.</u>			
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Woodlawn</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>6805 Richardson Road 21227</u>			
14. FATHER'S NAME FIRST <u>Frank</u> MIDDLE <u>G.</u> LAST <u>Benton</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Muriel</u> MIDDLE <u></u> LAST <u>Hamilton</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>219-20-5663</u>		17. INFORMANT ADDRESS <u>Robert E. John Same as #13</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC RENAL FAILURE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>RHEUMATOID ARTHRITIS</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 14</u> , 19 <u>84</u> , to <u>DEC 2</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>DEC 1</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Yakov Friedman</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>DEC 2, 1984</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>YAKOV FRIEDMAN</u>				22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-4-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk. Cem</u>		23d. LOCATION CITY OR TOWN <u>Woodlawn</u> COUNTY <u>Balto</u> STATE <u>Md</u>							
24. FUNERAL DIRECTOR NAME <u>MacNabb Funeral Home</u> ADDRESS <u>Catonsville Md</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 3 1984</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

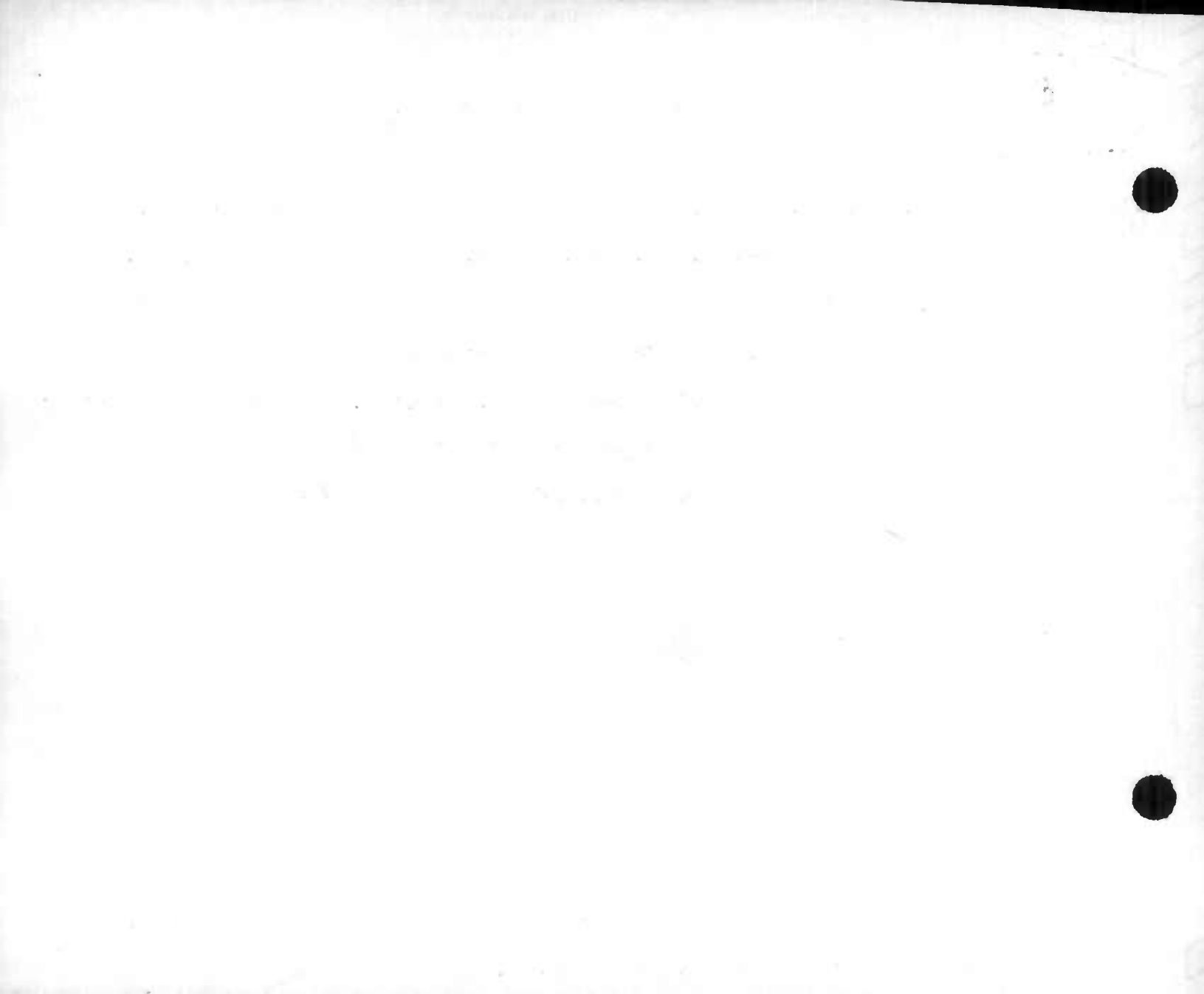


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 5 7
REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD, Maxwell MOSNEK Sr.		7a. DATE OF DEATH MONTH DAY YEAR 12 2 84		7b. HOUR 12:02 PM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 5 15		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. Md. MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. Gen. Hospt.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Vice Pres. Bandag Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Carroll		13c. STREET ADDRESS / ZIP CODE 4290 Wolf Hill Drive 21074			
14. FATHER'S NAME FIRST MIDDLE LAST Jason H. Mosner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances L. Maxwell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2		16b. SOCIAL SECURITY NO. 213-09-3136	
		17. INFORMANT Mrs. Irene D. Mosner		ADDRESS Hampstead, Md.			
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
		19a. DATE OF OPERATION					
		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-22</u> 19 <u>84</u> to <u>12-2</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12-2</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>msnafi</u> DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SHAFI</u>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/84		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home Reisterstown, Md.		25a. DATE REC'D BY REGISTRAR DEC 4 1984		25b. REGISTRAR'S SIGNATURE <u>Eline Davidson-Randall</u>			



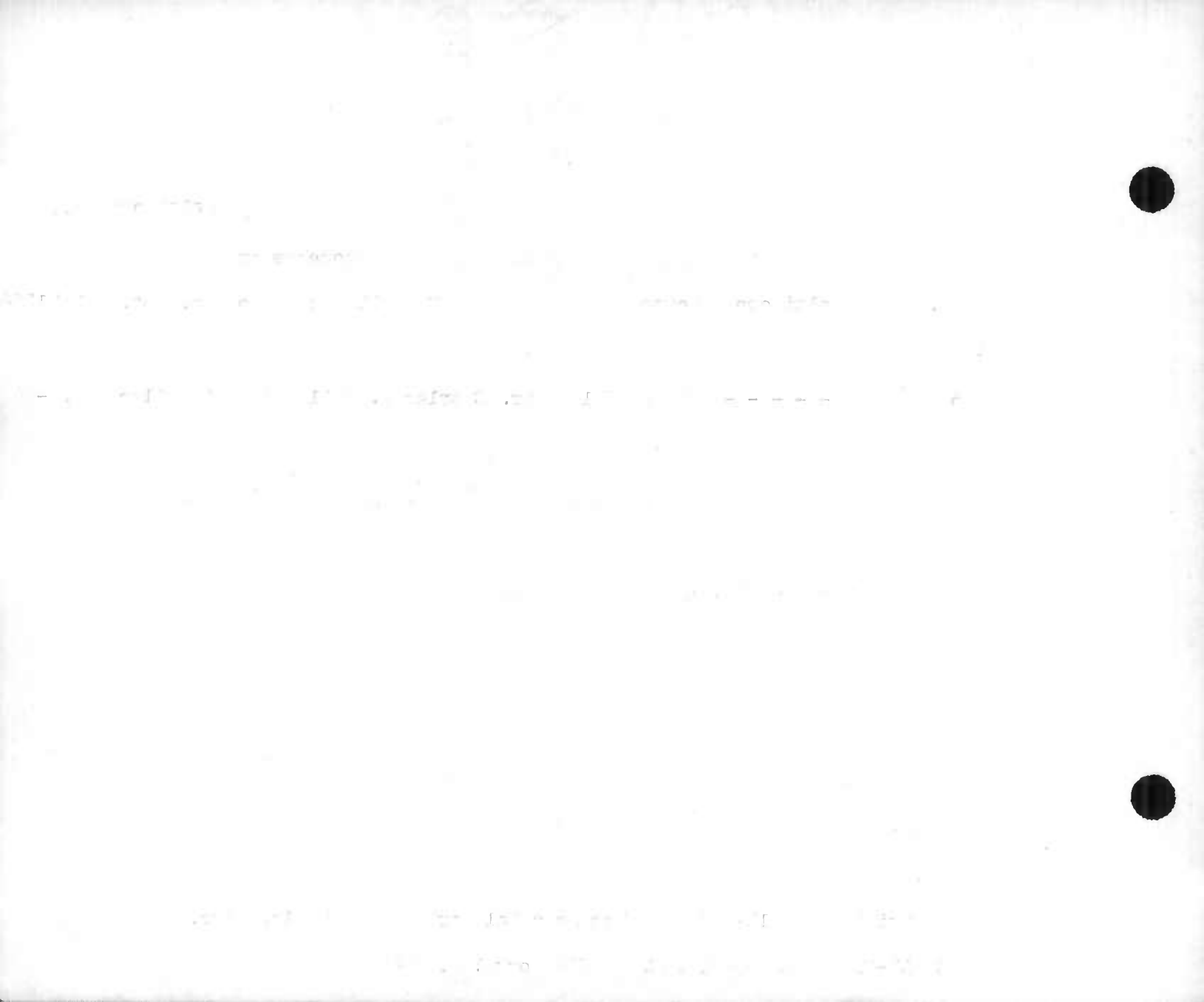
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transfer permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be contacted once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 5 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) HICKMAN D. MULLENNIX				2a. DATE OF DEATH MONTH DAY YEAR 12/27/84				2b. HOUR 11:00 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12/10/1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 6. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson Baltimore Co., MD.			
10. CITY OR TOWN OF DEATH Towson, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Storekeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 320 Stevenson La. Apt. A3 21204	
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO 428 26 5214		17. INFORMANT ADDRESS Mr. Charles O. Mullennix 605 Wilton Rd. -04			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebral Vascular Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 26 , 19 84 , to Dec 27 , 19 84 , that (I) (we) last saw the deceased alive on December 26 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE George E. LaRocco MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George E. LaRocco				22e. ADDRESS 7600 Oster Drive Towson, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/84		23c. NAME OF CEMETERY OR CREMATORY Lee Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Tupelo, Miss.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.				ADDRESS 6500 York RD.		25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE John S. ...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (B) should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 5 9 REG. NO.		
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST EVA	MIDDLE E.	LAST MUTH	2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 14, 1984			2b. HOUR 4:45P _M		
3. SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 20, 1913			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21234			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1411 TAYLOR AVENUE 21234		
14. FATHER'S NAME FIRST MIDDLE LAST COURTLAND DIETRICH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BIRTIE FERREL					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 219-05-5048		17. INFORMANT FRANK R. MUTH, SR.					ADDRESS 21220 CUNNING CIRCLE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CONGESTIVE CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>OBSTRUCTIVE LUNG DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>84</u> , to <u>12-13</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.												
22a. SIGNATURE <i>Saba Kulathungam</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/15/84				
22b. PHYSICIAN'S NAME (TYPE OR PRINT) SABA KULATHUNGAM, M.D.					22e. ADDRESS 6112 YORK ROAD 433-6301							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE DEC. 17, '84		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GAR.			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MD					
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON					ADDRESS 8521 LOCH RAVEN BLVD.			25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 2 6 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes T. MYERS						2a. DATE OF DEATH MONTH DAY YEAR December 25, 1984			2b. HOUR 11:53p_m		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 12 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2872 Nathaniel Way 21219			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph E. Woutiseth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Not Known							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-74-2926		17. INFORMANT ADDRESS Patricia Haas Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) myocardial Infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 25, 1984 , to December 25, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 25, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE Howard Bond						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Bond, M.D.						22e. ADDRESS 9618 Belair Road, Baltimore, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE John R. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 336-1234.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR		REG. NO. 3 2 2 6 1			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR		REG. NO. 3 2 2 6 1			
Mildred Nelson		12 3 1984		M					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female	Black	9 12 1923	61 YRS.	MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U. S. A.		Baltimore County		MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	3102 Woodford Pl. Apt. A. Foxhaven		Beautician		Beauty Salon Oxford				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		3102 Woodford Pl.			
Maryland		Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Apt. A. Baltimore, Md. 21207					
14. DECEASED'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME							
Alphonso Mack		Annie McCullough							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No.		220-12-6643		6800 Brompton Road Patricia A. Hamlin Baltimore, Md. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: + IMMEDIATE CAUSE (a) metastatic cancer lung. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 9 1983 to 12-3 1984 that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Steven A. Schonfeld						12-6-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Steven A. Schonfeld		Sinai Hospital of Baltimore		21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/7/1984		Baltimore Nat. Cem.		Baltimore, Maryland			
24. FUNERAL DIRECTOR'S NAME		25. ADDRESS		26. DATE REC'D. BY REGISTRAR		27. REGISTRAR'S SIGNATURE			
Nutter & Sons		2501 Gwynns Falls Parkway		DEC 12 1984					
Funeral Home Inc. Baltimore, Maryland 21216									

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 2 6 2

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rev. Walter P. Neudeck Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 22, 1984		2b. HOUR 6:45p.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 19, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Neudeck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paula -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 138-05-5224 A		17. INFORMANT ADDRESS Mrs. Gertrude P. Neudeck Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bradyarrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypokalemia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/22</u> , 19 <u>84</u> , to <u>12/22</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12/22</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (do) (do not) view the body after death.					
22b. SIGNATURE <i>P. Barrenechea</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Barrenechea, M.D.		22e. ADDRESS 9000 Franklin Square Drive, 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 28, 1984	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	25a. DATE REC'D. BY REGISTRAR DEC 27 1984
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland		ADDRESS		25b. REGISTRAR'S SIGNATURE <i>John H. Anderson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

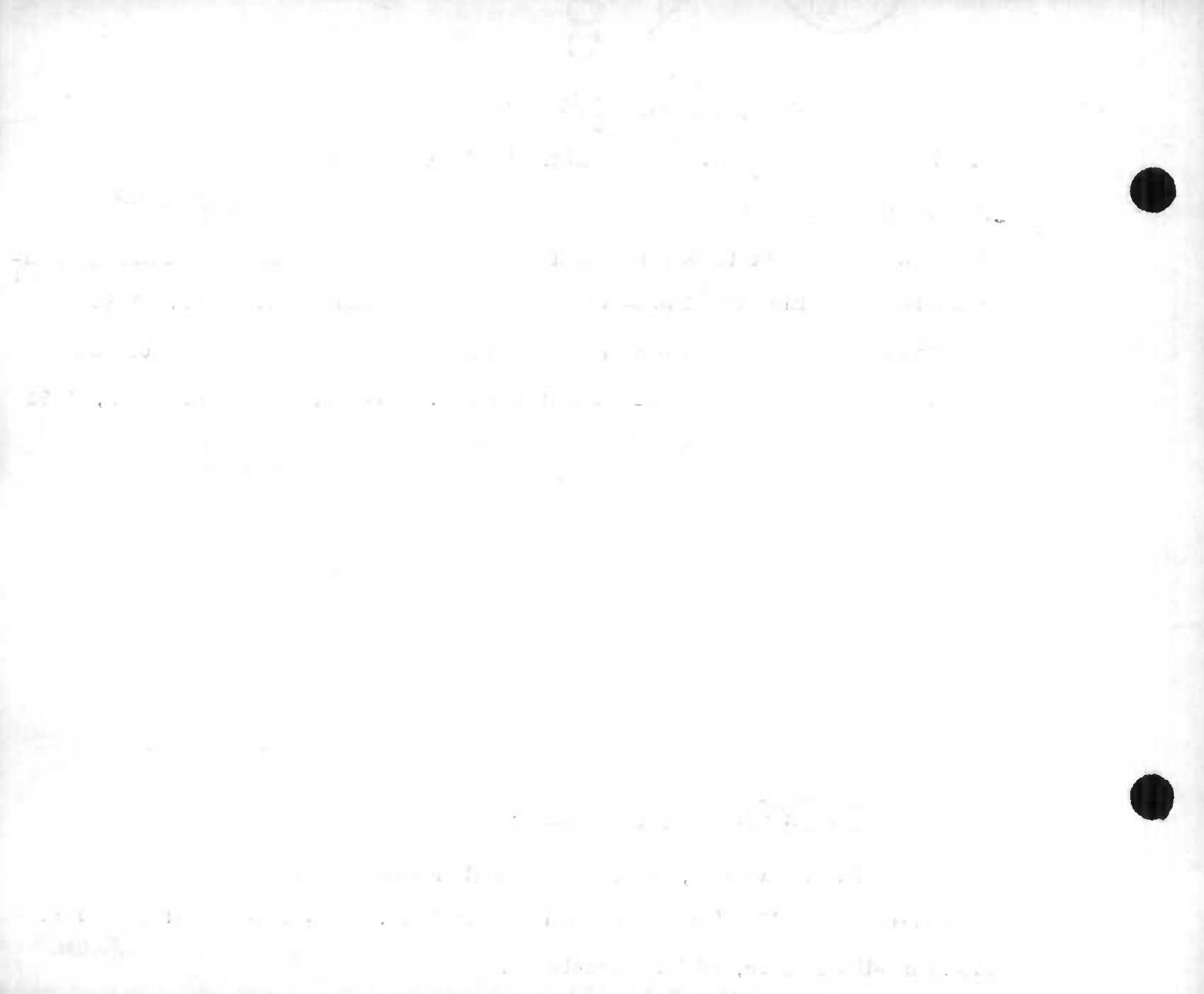
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 2 6 3

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) VERNON Marshall NORMAN		MONTH DAY YEAR 12 28 84		MONTHS DAYS HOURS MIN. 9:30 P.M.	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 24 1899	6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Timonium	13e. STREET ADDRESS / ZIP CODE 224 Chantry Rd., 21093		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Norman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Cushing			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-05-3581		17. INFORMANT ADDRESS Ellen H. Norman, 224 Chantry Rd., 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COLON CANCER WITH LIVER METASTASIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC 1 , 19 84 , to DEC 2 , 19 84 , that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE K.R. Faulkner MD		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. R. Faulkner, M. D.		22e. ADDRESS Stella Maris Hospice			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md.					
24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon, 10 W. Padonia Rd.		25a. DATE REC'D. BY REGISTRAR DEC 4 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 64 32264		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
FRANCIS S. OATES				12 19 84		6:00 PM			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		CAUCASIAN		10 19 21		63 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
WEST VIRGINIA		USA				BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ROSEDALE		1C CLEMENTINE CT. BLDG. 6		SALESMAN		INSURANCE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MARYLAND		BALTIMORE		ROSEDALE		1C CLEMENTINE CT. BLDG. 6 21237			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
JOHN OATES		HELEN MATHAI							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES)		17 INFORMANT ADDRESS					
YES		WW 11		212182774 ROSE OATES 1C CLEMENTINE CT. BLDG. 6					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio resp. arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>met. causes</u>								DUE TO, OR AS A CONSEQUENCE OF (c) <u>months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 21</u> , 19 <u>83</u> to <u>Dec 19</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec 3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<u>Albert L. Blumberg MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/20/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Albert L. Blumberg MD		6701 N. Charles St. Balto, 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		12/22/84		GARDENS OF FAITH		BALTO. BALTO. MD.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Jeffrey</u>		1211 Chesapeake Ave.		DEC 20 1984		<u>Davidson</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 4/83
(VRA 15, 4)

FOR
1- STATE
REGISTRAR

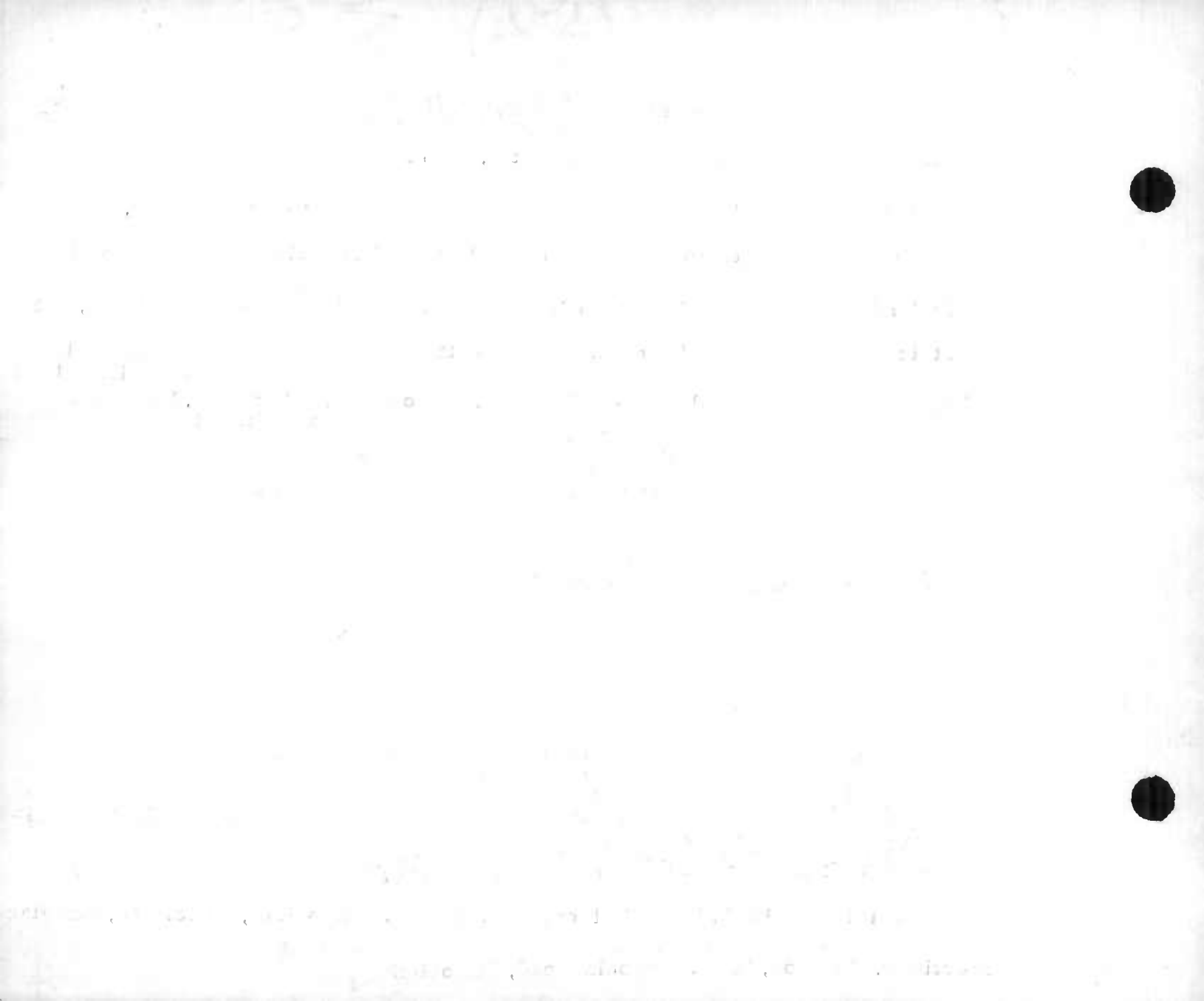
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 6 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Arthur O'Connell			2a. DATE OF DEATH MONTH DAY YEAR 12/13/84			2b. HOUR 11 09 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 4, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Josephs Hospital, 21204				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Manager		12b. KIND OF BUSINESS OR INDUSTRY Exporting	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Patrick O'Connell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annetta Campbell			16. STREET ADDRESS / ZIP CODE 1 Lemmon Grove Court, Apt F 21030			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW2 060-07-5254		17. INFORMANT ADDRESS Mrs. Caroline A. O'Connell, 1 Lemmon Grove Ct. Apt F				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Probable Amyloid heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Amyloidosis of Kidneys									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Amyloidosis of Kidneys									
19a. DATE OF OPERATION 12-7			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 12-13			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HISTORY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)			
22a. INJURY OCCURRED: AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION CITY OR TOWN COUNTY STATE			
22d. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-7 19 84 to 12-13 19 84 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-13 19 84 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. A (we) (all) (each) view the body after death.									
22e. SIGNATURE Samuel C.H. Lee, M.D.			22f. ADDRESS 7620-YORK ROAD TOWSON MD 21204			22g. DATE SIGNED 12/13/84		22h. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Balto. Co., Maryland		
24. FUNERAL DIRECTOR NAME Martin D. Lawson			25a. DATE REC'D. BY REGISTRAR DEC 18 1984			25b. REGISTRAR'S SIGNATURE [Signature]			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 6 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE R O'LEARY		2a. DATE OF DEATH MONTH DAY YEAR 12 18 84		2b. HOUR 1 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1898	
6. AGE (IN YEARS LAST BIRTHDAY) 86		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley Nursing Home	
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS 2601 E. Northern Pkwy 21214	
15. FATHER'S NAME FIRST MIDDLE LAST Stonewall Jackson Cochrane		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Pitcher		17. INFORMANT ADDRESS Same As 13e	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		19. SOCIAL SECURITY NO. 214-36-8847		20. DATE OF DEATH 12 18 84	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) shock DUE TO, OR AS A CONSEQUENCE OF (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) Vegetative life. gastrocnemius					
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTHORITY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
24a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE	
25. I certify that (I) (this hospital) attended the deceased from 19 80 , to 12/19/84 , that (I) (we) lost saw the deceased alive on 12/17/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
26. SIGNATURE Vuong Vu Nguyen M.D.		27. DEGREE PHYSICIAN		28. DATE SIGNED 12/19/84	
29. PHYSICIAN'S NAME (TYPE OR PRINT) Vuong Vu Nguyen M.D.		30. ADDRESS 6331 Belair Rd Baltimore, Maryland 06		31. DATE REC'D. BY REGISTRAR DEC 20 1984	
32. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		33. DATE 12/22 21/84		34. NAME OF CEMETERY OR CREMATORY Lorraine Park	
35. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland		36. ADDRESS Baltimore, Maryland		37. REGISTRAR'S SIGNATURE J. Davidson-Russell	

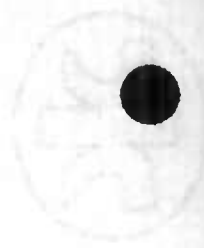
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY
CHICAGO, ILLINOIS 60637
U.S.A.
FEBRUARY 1964
TO THE DIRECTOR, NATIONAL BUREAU OF STANDARDS
WASHINGTON, D.C.
FROM THE DIRECTOR, NATIONAL BUREAU OF STANDARDS
WASHINGTON, D.C.
SUBJECT: [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

32267

1. STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
BEATRICE SMITH O'NEILL			12-22-84			4 P M		
3. SEX			4. RACE			5. DATE OF BIRTH		
Female			White			Feb. 2, 1900		
6. AGE (IN YEARS LAST BIRTHDAY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		
84			USA			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		
MD			Towson			Stella Maris Hospice		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. BALTIMORE CITY OR COUNTY OF DEATH		
Homemaker			Own Home			Baltimore County MD.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MD			Baltimore			Towson		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
A. Carroll Smith			Mary E. Meeks					
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mrs. Emerson Curley, Pasadena, MD			PART 1. DEATH WAS CAUSED BY:					
			IMMEDIATE CAUSE (a) Cerebral Thrombosis					
			DUE TO, OR AS A CONSEQUENCE OF					
			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
			DUE TO, OR AS A CONSEQUENCE OF					
			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-10, 1980, to 12-22, 1984, that (I) (we) lost saw the deceased alive on 12-17, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED		
			Eddie NAKhuda M.D.			12-22-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. LOCATION		
			2300 Dulaney Valley Rd. Towson, Md.			CITY OR TOWN COUNTY STATE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			12/27/84			New Cathedral		
24. FUNERAL DIRECTOR			24a. DATE REC'D. BY REGISTRAR			24b. REGISTRAR'S SIGNATURE		
NAME ADDRESS			DEC 26 1984			John Davidson-Randall		
4905 York Road Balto., MD 21212								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CESIDIO		PACIOTTI						DEC. 23				1984	M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
M.		W.		4/29/34		50		YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
ITALY		USA				BALTO. COUNTY						MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
ESSEX		333 A. TOWNSEND RD.		IRON WORKER										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
MD		BALTO		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		333 A. TOWNSEND RD.				21221		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST				
GIULIO		PACIOTTI				ONORINA		MAI						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
JACK No		218445452		ESILDE PACIOTTI		ABOVE								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
		liver failure		(b) hepatocellular cancer		7 months								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 19 84, to 12/1, 19 84, that (I) (we) last saw the deceased alive on 12/15, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED						
		Stanley E. O'Order		MD				12/26/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
		Johns Hopkins 601 N. Broadway												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
BURIAL		12/27/84		OAK LAWN		BALTO. MD.								
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
J. G. CONNELLY		300 MACE		DEC 28 1984		Julia Davidson-Randall								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						3 2 2 6 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Mr. Charles David Palmer					2a. DATE OF DEATH MONTH DAY YEAR December 23 1984				2b. HOUR 7:10 PM		
1. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 15 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3109 Offutt Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY McDonogh School			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3109 Offutt Road 21133			
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Palmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Stofle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-4179		17. INFORMANT Mrs. Elva E. Palmer		ADDRESS 3109 Offutt Road Randallstown Maryland		21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19, 1984 to Dec. 23, 1984 , that (I) (we) last saw the deceased alive on Dec. 23, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Shassem Pournotabadi, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-23-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM POURNOTABADI				22e. ADDRESS Balto. Co. Gen. Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133						25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 7 0
REG. NO.

1 - FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Delores Faye PALMERINO		December 16, 1984		2:00A M	
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 3 1945	6. AGE (IN YEARS LAST BIRTHDAY) 39	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE AND NATURE OF MOST OF WORKING LIFE) Clerk	12b. KIND OF BUSINESS OR OFFICE Business Office	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Essex 21221	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 764 Seawall Rd. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Stephens		15. MOTHER'S MAIDEN NAME Thelma Cheek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212 44 0873		17. INFORMANT ADDRESS Charles M. Palmerino, Jr. Husband Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest, Anoxic Brain Damage Following Previous Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Scleroderma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 7, 1984 to December 16, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 16, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death.					
22b. SIGNATURE J. Zlotnick, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Zlotnick, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/19/84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.					
24. FUNERAL DIRECTOR Brzezinski Funeral Home PA		25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "RECEIVED" and "JAN 1941" are visible.]

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 7 1 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIUS WALTER PELLICOT				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1984			2b. HOUR 1:40 P_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1995		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Masonic Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Hardware Store			
13a. STATE Maryland			13b. COUNTY BALTO.		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2913 Stockton Rd. 21131		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Pellicot					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mueller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 217-26-6889		17. INFORMANT ADDRESS Margaret E. Pellicot Maryland Masonic Home						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Heart Failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Paul Rivas</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-25-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Rivas, M.D.					22e. ADDRESS Maryland Masonic Home, Cockeysville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Gdns. of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea, Balto., Co., Md.				
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212					ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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RECEIVED

TO: Mr. J. Edgar Hoover
FROM: Mr. [illegible]
SUBJECT: [illegible]

RE: [illegible]
DATE: [illegible]

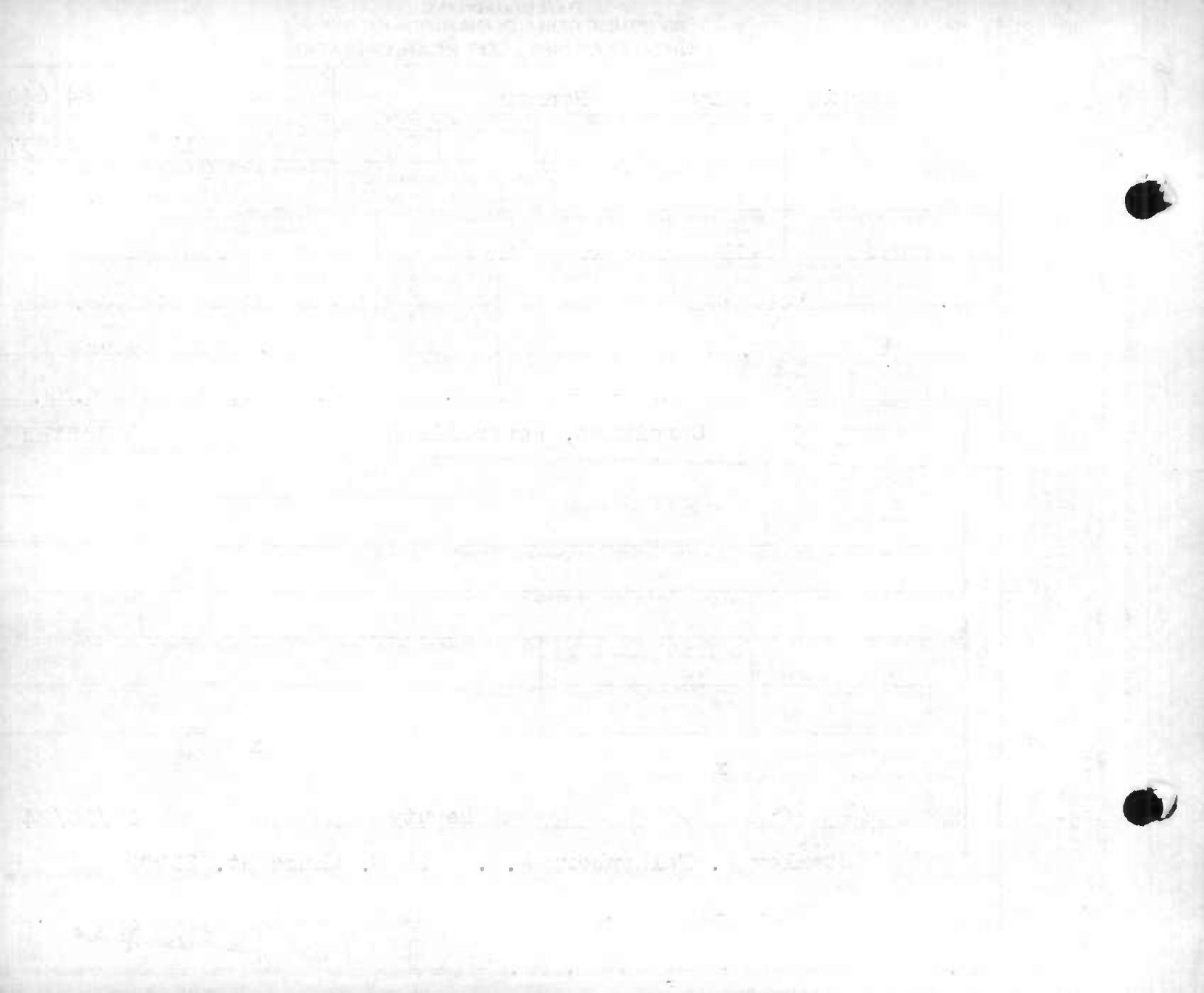
Very truly yours,
[illegible]
Special Agent in Charge

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 2 7 2	
1. DECEASED NAME (TYPE OR PRINT) Margie Mary Penner								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12/8 1984		2b. HOUR 640 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 31 YEAR 25		6. AGE (IN YEARS) LAST BIRTHDAY 59 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH Hampstead				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18621 Brick Store Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HWF		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 18621 Brick Store Rd. 21074	
14. FATHER'S NAME FIRST Gilbert MIDDLE F. LAST Raines				15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE M. LAST Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 219-12-3184		17. INFORMANT ADDRESS Mr. Floyd E. Bull, Hampstead, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, generalized DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Stanley Z. Felsenberg</i>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 12/10/84			
EXAMINER'S NAME (TYPE OR PRINT) Stanley Z. Felsenberg M.D.				ADDRESS 11 E. Chase St. 21202							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-11-84		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Balto Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md.						25a. DATE REC'D. BY REGISTRAR DEC 17 1984 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 31201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 2 7 3

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Cynthia		MIDDLE A.		LAST Perdue		2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 12-29 1984		2b. HOUR M 10:45 a.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 5 59		6. AGE (IN YEARS) (LAST BIRTHDAY) 25 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-29 1984		2d. HOUR a.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			
10. CITY OR TOWN OF DEATH Essex				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wallace Campbell				12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9806 Matson Rd. 21220			
14. FATHER'S NAME FIRST MIDDLE LAST Leo B. McKeon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cynthia J. Camuso				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 219-74-4022		17. INFORMANT ADDRESS J. Mark Perdue 9806 Matson Rd. 21220	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral Injuries</u> 8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:15x 12-29 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger was ejected and trapped under auto							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) intersection				21f. LOCATION STREET CITY OR TOWN COUNTY STATE King Ave. & Franklin Square Dr., Rossville, Balto. Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 12-30-84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Connolly Funeral Home of Dundalk								25a. DATE REC'D. BY REGISTRAR JAN 4 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 2 7 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORACE JEAN PEREGOFF					2a. DATE OF DEATH MONTH DAY YEAR 12 12 '84			2b. HOUR 8:02A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 20, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL			
13a. STATE MARYLAND					13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN PIKESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST BERYL KAMINSKY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 047-32-0878		17. INFORMANT MR. MYER PEREGOFF		16. WARREN PARK DR. #21208		APT. 2A			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div> DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) Claudication with peripheral vascular disease </div> <div> DAYS YEARS </div> </div>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GASTROINTESTINAL BLEEDING											
19a. DATE OF OPERATION 12/10/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CLAUDICATION WITH PERIPHERAL VASCULAR DISEASE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (a) (this hospital) attended the deceased from 12/10, 19 84, to 12/12, 19 84, that (we) last saw the deceased alive on 12/12, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Martin Magram</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN MAGRAM, M.D.						22e. ADDRESS 7401 OSLER DR. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-13-84		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD				
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE <i>Lila Davidson-Randall</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 7 5
REG. NO.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 2 7 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL Berry PERRY			2a. DATE OF DEATH MONTH DAY YEAR 12/27/84		2b. HOUR 1:00P^M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 18 96		6. AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Engineer		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8031 York Road 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Perry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Berry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI	17. INFORMANT ADDRESS Mr. R.W. Perry 6413 Pinehurst Road 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ACUTE CONGESTIVE CARDIAC FAILURE; ARRHYTHMIAS CHOLECYSTECTOMY					
19a. DATE OF OPERATION 12/11/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE CHOLECYSTITIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/27 19 84 to 12/27 19 84 , that (I) (we) last saw the deceased alive on 12/27 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
22b. SIGNATURE Ralph W Fawcett		DEGREE MD		22c. DATESIGNED 12/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. R.W. FAWCETT		22e. ADDRESS GBMC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-31-84	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home		ADDRESS 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR 12-27-85	
				REGISTRAR'S SIGNATURE Jana Davidson-Randall	

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BALTIMORE COUNTY

WILLIAM H. CHURCH

TOWSON

WILMINGTON

ACUTE CHOLECYSTITIS
ACUTE CONGESTIVE CARDIAC FAILURE; ARTERIOVENOUS CHOLECYSTITIS

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10/27

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10/27

10/27

CHERRY

WILLIAM H. CHURCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 7 6	
1 - FOR STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FELIX ANTHONY PETKUS						2a DATE OF DEATH MONTH DAY YEAR 12 - 1 - 84			2b HOUR 6 P M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1886		6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10 CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10874 Sandringham Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor			12b KIND OF BUSINESS OR INDUSTRY Clothing		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Cockeysville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 10874 Sandringham Road 21030		
14 FATHER'S NAME FIRST MIDDLE LAST (unknown)				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-03-5296		17 INFORMANT Frances P. Suter			ADDRESS Same as # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE N. Rosenblum					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-2-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. ROSENBLUM					22e ADDRESS 7600 OSLEA DRIVE TOWSON, MD 21204						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 12/4/84		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.			
24 FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A.					25a. DATE REC'D. BY REGISTRAR DEC 4 1984						
1630 Edmondson Avenue, Catonsville, Md. 21228					25b. REGISTRAR'S SIGNATURE Sha Davidson-Rendell						

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 2 7 7	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian C. Pinder						2a. DATE OF DEATH MONTH DAY YEAR December 26, 1984				2b. HOUR A M 9:45 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 3 1897		6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2000 Odell Avenue Apt. 619				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress-Marlboro Shirt				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2000 Odell Ave. Apt. 619 21237			
14. FATHER'S NAME FIRST MIDDLE LAST James E. Collier				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine A. Gregory							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-0800		17. INFORMANT ADDRESS Leona L. Swayne 725 S. Ponca St. Balto., MD. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Living alone, in supervised housing</u>											
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>None</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>November 16</u> to <u>Dec 17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased <u>alive on Dec 17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Hugh R. Williams</u>				DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/26/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Hugh R. Williams M.D.				22e. ADDRESS <u>Franklin Square Hosp. Balto., Md. 21237</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/26/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue. Dundalk, Maryland 21222						25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE <u>Lila Davidson-Rendall</u>			

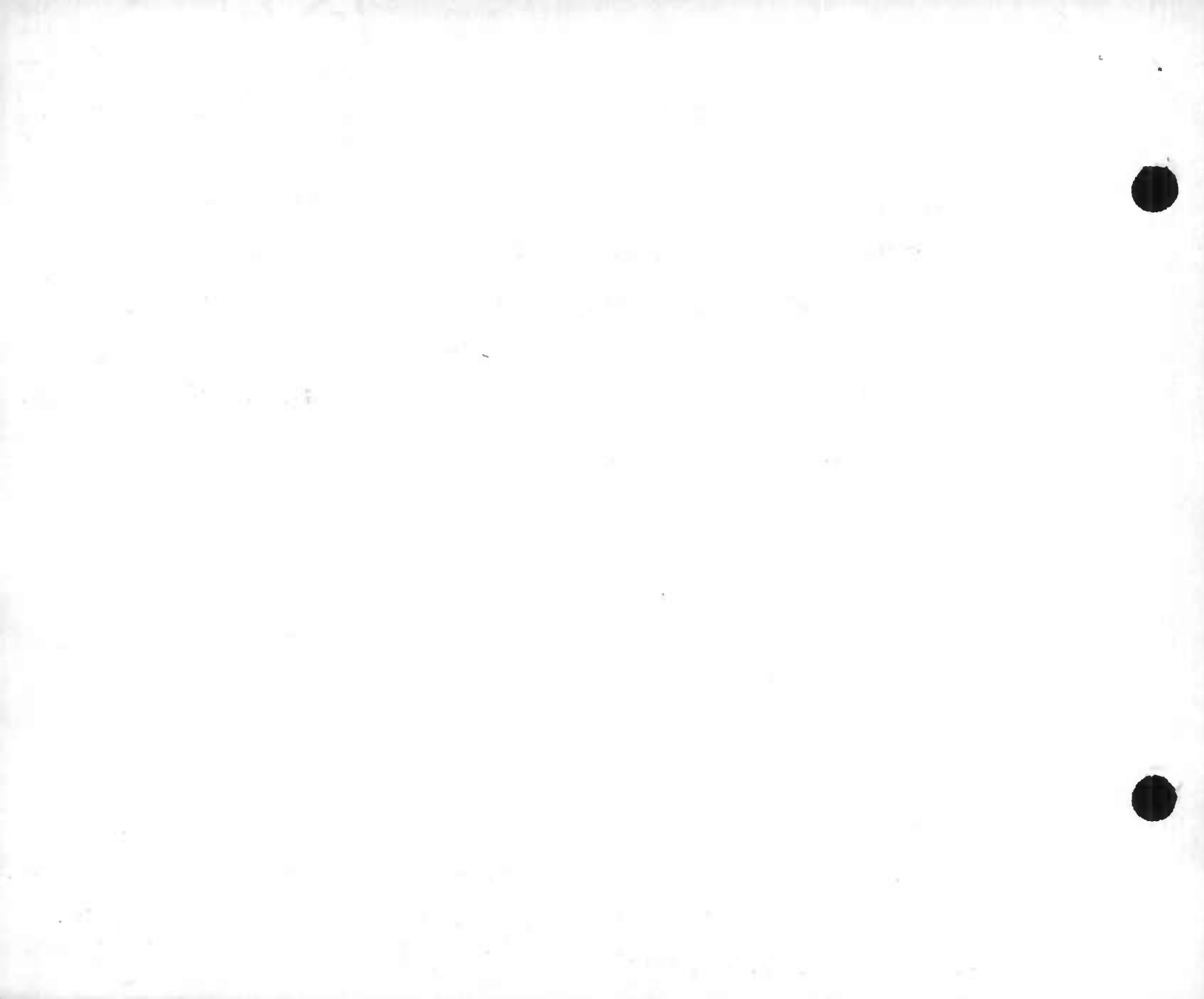
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 7 8	
1 - STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELI HERBERT PINERMAN						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28 1984			2b. HOUR 8:30A.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 6, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		8. IF UNDER 24 HRS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMINISTRATOR		12b. KIND OF BUSINESS OR INDUSTRY BALTO. HEBREW CONG.			
13a. STATE MARYLAND						13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 3506 SEVEN MILE LANE (21208)	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS PINERMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE GOODMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-01-0857		17. INFORMANT ADDRESS MRS. PAUL WOLMAN, APT. E-2(21215) SR. 6414 PARK HEIGHTS AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrhythmia - arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis heart dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2 yrs</u> <u>10 yrs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Parkinsonism - Drab. Mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13/84</u> to <u>Dec 28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/13/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <u>Jonas Cohen MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/>				22c. DATE SIGNED DEC. 29, 1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JONAS COHEN				22e. ADDRESS 6702 Park Heights Avenue (21215) Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/30/84		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN, BALTO., MD.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC.				BALTIMORE, MD. ADDRESS 6010 REISTERSTOWN RD.		25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>			

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 2 2 7 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RITA JOYCE PLOTCHYK				2a. DATE OF DEATH MONTH DAY YEAR DEC. 8, 1984		2b. HOUR M			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10/11/20		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 64		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.			
10. CITY OR TOWN OF DEATH MIDDLE RIVER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 105 TRAILWAYS RD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN MIDDLE RIVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2122A 105 TRAILWAYS RD.	
14. FATHER'S NAME FIRST MIDDLE LAST FRED LAPOINTE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 20052		17. INFORMANT ADDRESS JANICE PLOTCHYK EULFORD AVE 3133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe chronic Obstructive lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> <u>8 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 11</u> , 19 <u>85</u> , to <u>Dec 8</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Nov 8</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Mark M. Applefeld				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark M. Applefeld				22e. ADDRESS Vniv. of MD Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/10/84		23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR DEC 12 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 8 0
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Laurence C. Post, M.D.		2a. DATE OF DEATH MONTH DAY YEAR 12-17-84		2b. HOUR 10:14 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 6 11		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County Baltimore, Md.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multimedical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor		12b. KIND OF BUSINESS OR INDUSTRY
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Balt.	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 9 Oakbridge Ct 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Orne Post		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Leonard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 718-09-5010		17. INFORMANT ADDRESS Mrs. Beatrice L. Post Same as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Art CVD DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mrs 5 yrs 30 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: peripheral vascular disease & diabetic gangrene, pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1975 to 12 18 1984 , that (I) (we) lost saw the deceased alive on 12-15 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frank E. Leslie		DEGREE Attending Physician		22c. DATE SIGNED 12-18-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. E. Leslie		22e. ADDRESS 3501 St Paul St. Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 18, 1984		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR DEC 20 1984	
25b. REGISTRAR'S SIGNATURE [Signature]					

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MEDICAL CERTIFICATION



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MEDICAL CERTIFICATION

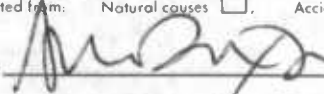
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 8 1 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Pearl POSTERARO				2a. DATE OF DEATH MONTH DAY YEAR December 18, 1984			
3. SEX Female				2b. HOUR 10:05P _M			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 20 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietitian		12b. KIND OF BUSINESS OR INDUSTRY Cafeteria	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) Seamon Vernatter		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Josie Olaker		13e. STREET ADDRESS / ZIP CODE 3433 Yorkway 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-18-9215		17. INFORMANT Nicholas R. Posteraro		ADDRESS Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest, Metastatic Lung Cancer, Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Metastasis of Lung Cancer to Brain							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 12, 1984, to December 18, 1984, that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on December 18, 1984, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour from the causes stated above, <input type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan M. Seltzer, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan M. Seltzer, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/84		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson	

18 FEB 1964

(1)

[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "RECEIVED" and "FEBRUARY" are visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 2 8 2	
1. DECEASED NAME (TYPE OR PRINT) ADELE Dorothy PRELLER						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 6 1984		2b. HOUR AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 30, 1947		6. AGE (IN YEARS) LAST BIRTHDAY YRS 37		7. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 11 1984		7d. HOUR 3p	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County					
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) water - Loch Raven off Warren Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21047 2603 Greene Lane Fallston			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Driver of auto that lost control DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/6 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) went down embankment into water					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-12-84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 15, 1984		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR DEC 13 1984		25b. REGISTRAR'S SIGNATURE			



Female
 April 20, 1907
 U.S.A.

Rockyville
 Maryland
 Baltimore
 x 2007 Green Lane
 7007
 Rockyville



[Handwritten signature]

Rockyville
 Dec. 17, 1907
 Grant Farm Home, Green
 Maryland
 2007
 7007
 Rockyville

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 8 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) SHIRLEY F. PRICE						2a. DATE OF DEATH MONTH DAY YEAR December 19, 1984				2b. HOUR 3:45 P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 14, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 60		7 UNDER 1 YEAR MONTHS DAYS YRS.		7 UNDER 24 HRS. HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, county MD.					
10. CITY OR TOWN OF DEATH Rodgers Forge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 Dunkirk Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Rodgers Forge						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 300 Dunkirk Road 21212			
14. FATHER'S NAME FIRST MIDDLE LAST Herman August Feldmann						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Brown McCormick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-26-7966		17. INFORMANT ADDRESS Mr. Wm.R.Price Jr. 300 Dunkirk Road 21212							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MM.	
DUE TO, OR AS A CONSEQUENCE OF (b) EXSANGUINATION											
DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CA OF PAROTID GLAND										1 YR.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: HTN; CROHN'S DISEASE; C.A.D.; CA OF LUNG											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/22, 1961 to 12/19, 1984 , that (I) (we) last saw the deceased alive on 11/12, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Donald L. Somerville, MD.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Somerville						22e. ADDRESS 500 Virginia Ave. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-84		23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Presby.		23d. LOCATION CITY OR TOWN COUNTY Jacksonville Baltimore Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212						25a. DATE REC'D. BY REGISTRAR DEC 21 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the body until the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 2 8 4	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MARY ANN PRIVOTT						2a. DATE OF DEATH MONTH DAY YEAR 12/10/84		2b. HOUR 6:45 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 08 44		6. AGE (IN YEARS LAST BIRTHDAY) 40		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1642 Ralworth Ave. 21218					
14. FATHER'S NAME FIRST MIDDLE LAST Alex Woodson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florine Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS James Privott 1642 Ralworth Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST METASTATIC TO LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) LIVER FAILURE, METABOLIC ACIDOSIS, RENAL FAILURE											
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED				9c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		9d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/28 , 19 84 , to 12/10 , 19 84 , that (I) (we) lost saw the deceased alive on 12/10 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ralph W Fawcett</i>				DEGREE MD				22c. DATE SIGNED 12/10/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. R.W. FAWCETT				22e. ADDRESS GBMC							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/15/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

BP

RECEIVED

1950

NOV 10

UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON

TO THE ATTORNEY GENERAL

FROM THE DIRECTOR, FBI

RE: [illegible]

10/10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 8 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FREDERICK C. PYNE		2a. DATE OF DEATH MONTH DAY YEAR Dec. 19, 84		2b. HOUR 5:30 A	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 8 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Agaña, Guam	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) B.C.G.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military		12b. KIND OF BUSINESS OR INDUSTRY U. S. Army
13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY Linwood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Glover Pyne		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Roosevelt Jones			
16a. DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) 1924 to Retirement		16b. SOCIAL SECURITY NO. 081-03-0968		17. INFORMANT ADDRESS Frederick W. Pyne, Linwood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Dec. 17, 1984 , to Dec. 19, 1984 , that (I) (we) last saw the deceased alive on Dec. 19, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Grassem Pourmotabed, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GRASSEM POURMOTABED		22e. ADDRESS Balti. Co. Gen. Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/19/84		23c. NAME OF CEMETERY OR CREMATORY Services Carroll Cremation	
23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Maryland		23e. DATE REC'D. BY REGISTRAR DEC 24 1984			
24. FUNERAL DIRECTOR NAME D. D. Windsor		24b. ADDRESS New Windsor, Md.			
25a. REGISTRAR'S SIGNATURE John Davidson-Randall		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

RECEIVED
OFFICE OF THE
DIRECTOR

Baltimore

John, Guy

Military

1934

U.S. Department of War

Carroll, Howard

John, Guy

Frederick, Glover

1934

to Retirement 01-01-1934 Frederick W. Guy, Howard, Guy

Director, Bureau

Office of the Director

Washington

U.S. Department of War

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET			2a. DATE OF DEATH MONTH DAY YEAR 12-15-84			2b. HOUR 7:40 AM		
3. SEX Female			4. RACE Cauc.			5. DATE OF BIRTH MONTH DAY YEAR 12-25-91		
6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS 1 MONTHS 1 DAYS			8. IF UNDER 2 YEARS MONTHS DAYS 1 MONTHS 1 DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD.		
10. CITY OR TOWN OF DEATH Towson, Md.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY Home			13a. STREET ADDRESS / ZIP CODE 21204			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Hintz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Goeller			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b. SOCIAL SECURITY NO. 213-20-9994			17. INFORMANT Thomas Young Jr.			ADDRESS 5008 R Emmell Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Sept 1 19 83 to Dec 15 19 84 , that (I) (we) last saw the deceased alive on Dec 15 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE EDDIE NAKHODA, MD.			DEGREE MD.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED DEC 18 1984
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 2300 Dulaney Valley Rd., Towson, Md 21204			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		
23b. DATE 12-19-84			23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Schumaker Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213						25a. DATE REC'D. BY REGISTRAR DEC 18 1984		
25b. REGISTRAR'S SIGNATURE John Davidson-Randall								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

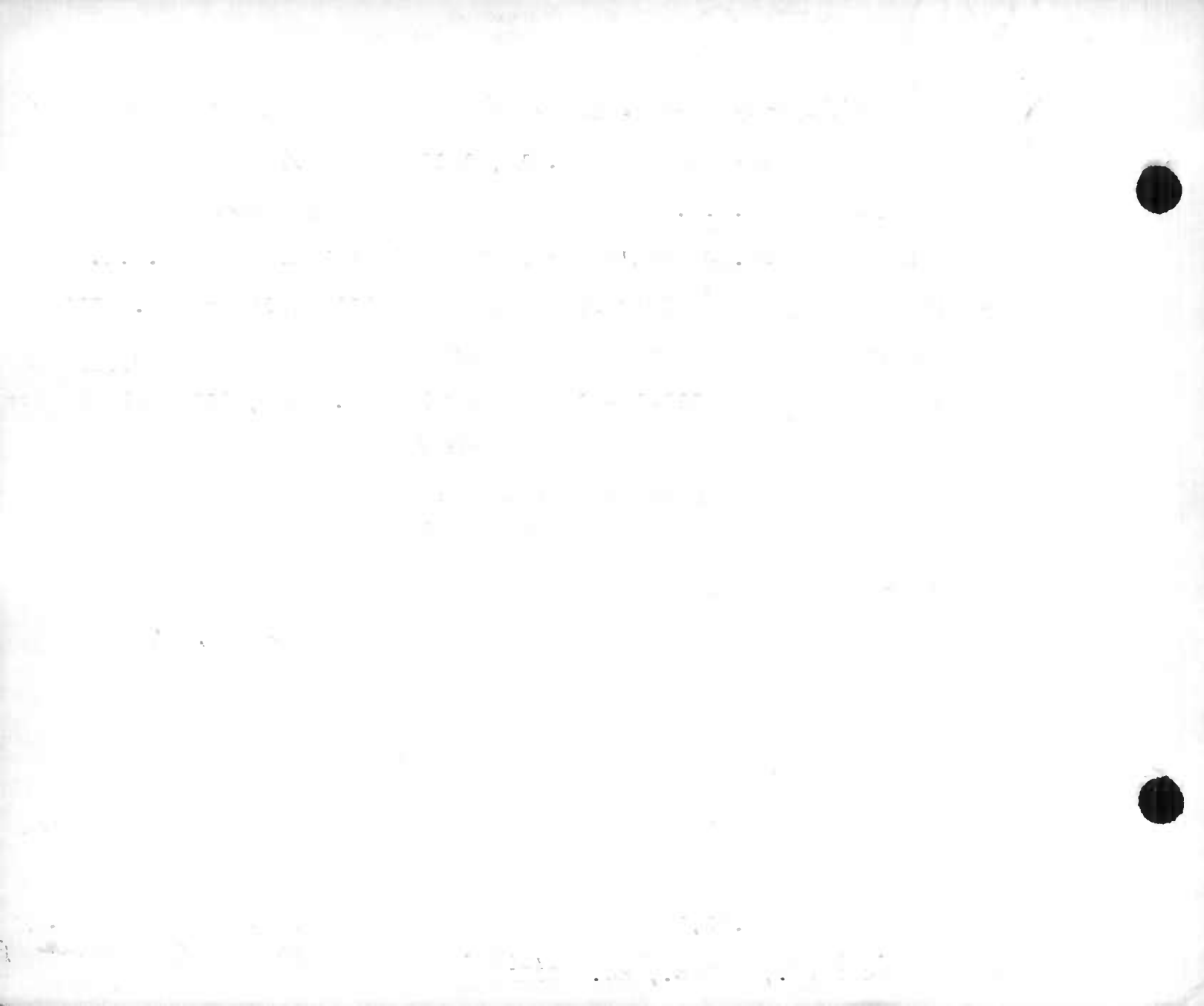
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 8 7

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM Frederick RAAB			2a DATE OF DEATH MONTH DAY YEAR 12-19-84		2b HOUR 1:10 P
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.	
10 CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b KIND OF BUSINESS OR INDUSTRY M.T.A.
13a STATE Maryland	13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Raab		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Zang			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-10-0167A		17 INFORMANT ADDRESS 21234 Marvalene S. Raab, 3115 Orlando Ave	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) OLD CVA					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR NOV. 30 1984		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 (PART I) OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from NOV. 30 1984 to DEC. 19 1984 , that (I) (we) last saw the deceased alive on DEC 19 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Fausto Q. Aquino Jr. MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 12-19-84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) FAUSTO Q. AQUINO JR				22e ADDRESS 8713 HARFORD RD. 21234	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Dec. 22, 1984		23c NAME OF CEMETERY OR CREMATORY Parkwood	
23d LOCATION CITY OR TOWN Baltimore		COUNTY Md.		23e DATE REC'D BY REGISTRAR DEC 21 1984	
23f REGISTRAR'S SIGNATURE Robert C. Altenburg					
23g ADDRESS 6009 Harford Rd., Balto., Md. 21214					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ADDITIONAL INFORMATION: Item 18 shows any injury, or other traumatic event, if any. Item 21 is marked or checked if death was due to a violent or sudden cause. If item 21 is marked, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 8 8
REG. NO.

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 8 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH M. RADCLIFFE						2a. DATE OF DEATH MONTH DAY YEAR 12 5 84		2b. HOUR M	
3. SEX Femlae		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 28 19		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD			
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14102 Cuba Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14102 Cuba Rd. 21030	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Cockeysville					
14. FATHER'S NAME FIRST MIDDLE LAST James E. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie R. Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-42-5270		17. INFORMANT ADDRESS Jesse Radcliffe 14102 Cuba Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis								48 yr.	
DUE TO, OR AS A CONSEQUENCE OF (c) High Blood Pressure								50 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cerebrovascular Accident									
19a. DATE OF OPERATION 12/4/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, PARK, OR OTHER PARK, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 14102 CUBA RD. COCKEYSVILLE MD					
22a. I certify that (1) this hospital attended the deceased from above, (2) the deceased died on (date and hour) 12/8/84 at 9:00 P.M., and that in my (our) opinion death occurred on the date and hour and from the causes stated								22b. DATE SIGNED 12/4/84	
22c. SIGNATURE R. L. Broadwater, M.D.				22d. ADDRESS LABORATORY 10 WARREN ROAD COCKEYSVILLE, MD. 21030				22e. DATE SIGNED 12/8/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/84		23c. NAME OF CEMETERY OR CREMATORY Cockeysville United Meth		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H, Inc. 1101 E. North Ave									

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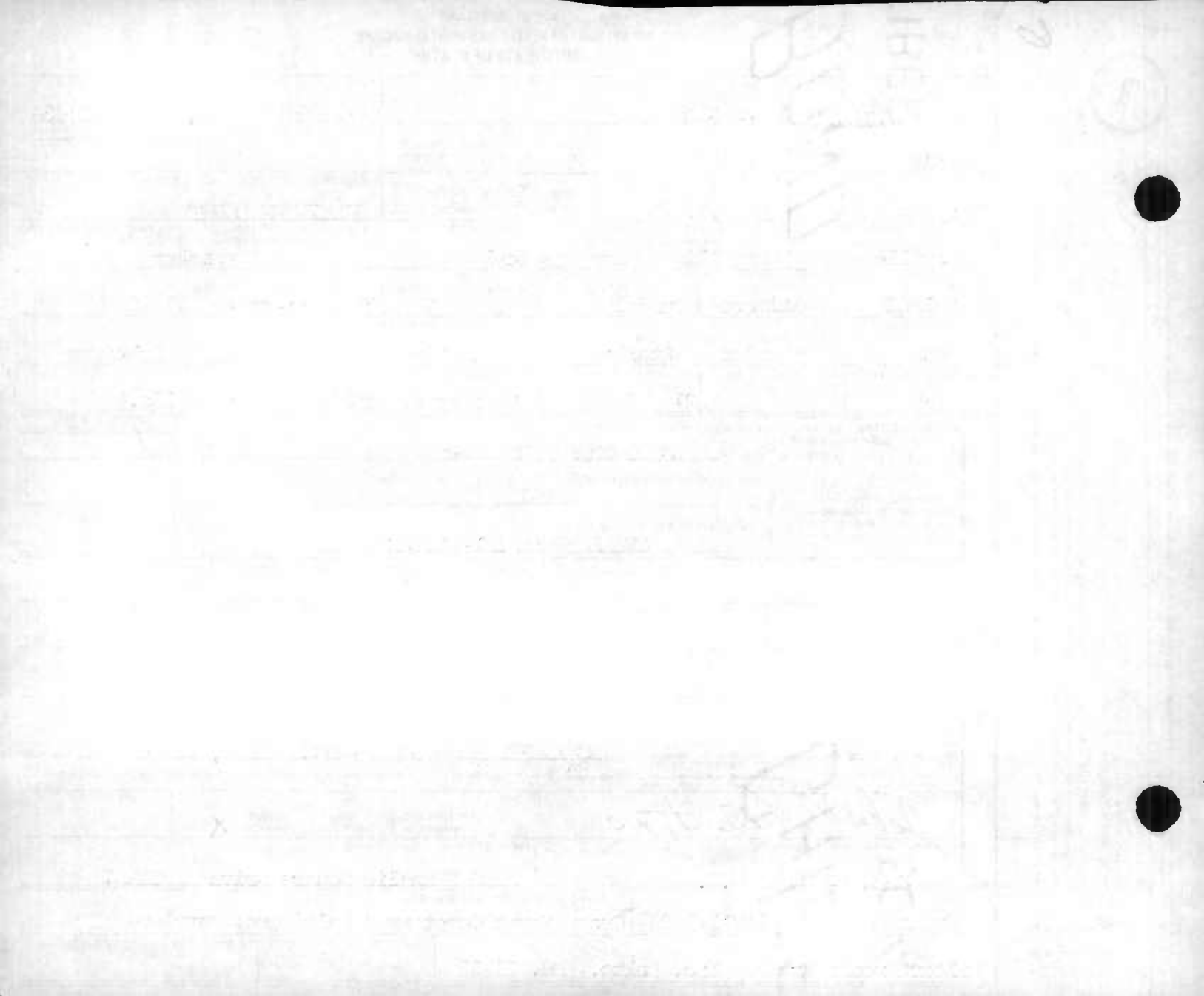
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 8 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) LILLIAN A RANKIN						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9, 1984				2b. HOUR 11:45AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 13 1915		6. AGE (IN YEARS, LAST BIRTHDAY) 69 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7200 Dunmarway 21222		
14. FATHER'S NAME FIRST MIDDLE LAST John Charles Starkey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Schriver								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219/03/1500		17. INFORMANT Charles E. Rankin				ADDRESS (same as 13e.)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) SMALL BOWEL INFARCTION											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 23, 1984 , to DECEMBER 9, 1984 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on DECEMBER 9, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (not) view the body after death.												
22b. SIGNATURE <i>John M. Vincent, M.D.</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN VINCENT M.D.						22e. ADDRESS 9000 FBanklin Square Drive 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/11/1984		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc. Balto., Md. 21222						25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE <i>Walter Brooks Bradley</i>				

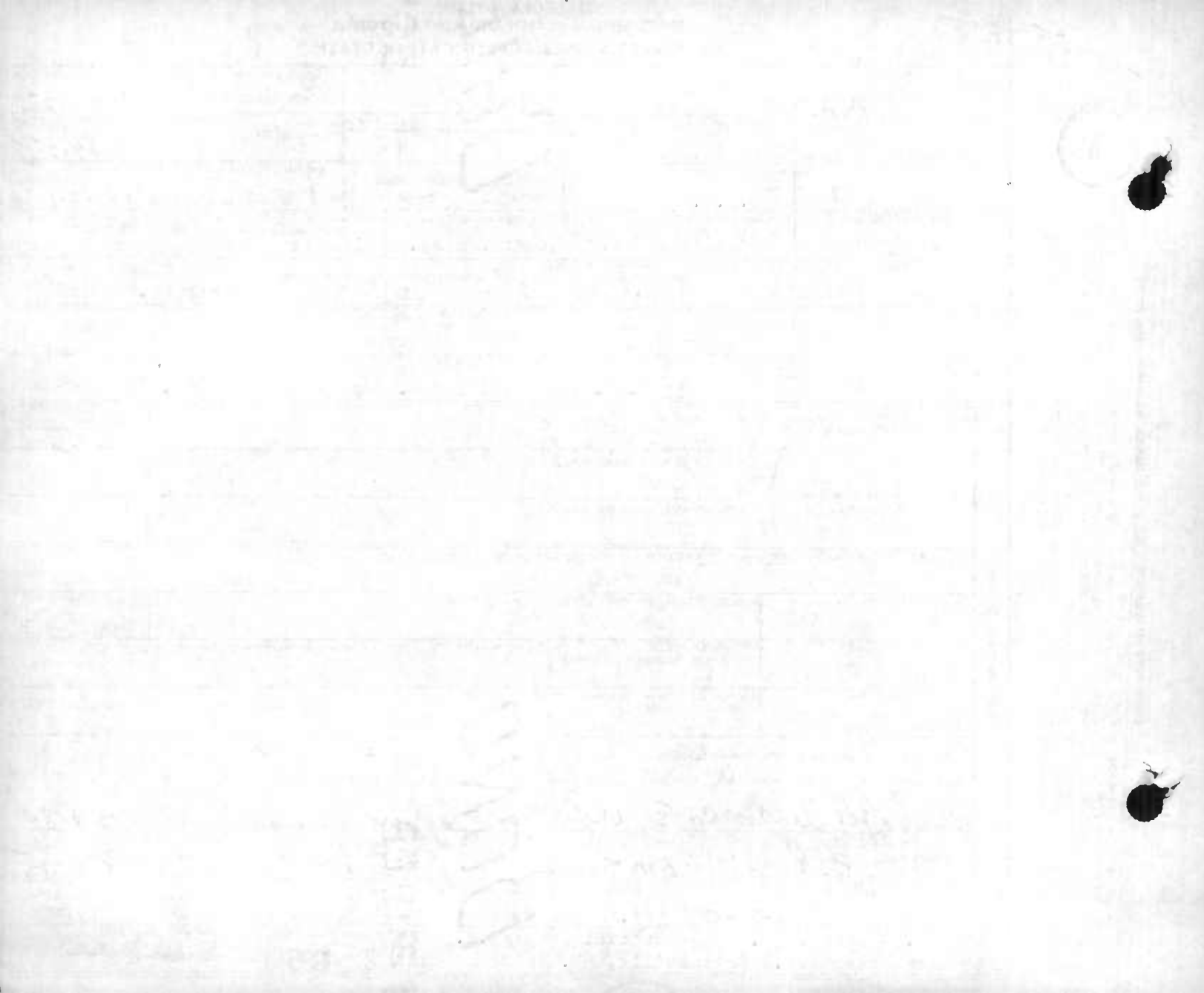


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM JM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 2 9 0 REG. NO.	
1- FOR STATE REGISTRAR KAY FERN REED											
1. DECEASED NAME (TYPE OR PRINT) KAY Fern Reed						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 12 DAY 29 YEAR 1984		2b. HOUR 2:41 M PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH June DAY 29 YEAR 1935		6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 12 29 1984	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
11. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Checker		12b. KIND OF BUSINESS OR INDUSTRY Food Store	
13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 7204 Stoney Bar Rd.						13f. ZIP CODE 21207					
14. FATHER'S NAME FIRST Charles MIDDLE Irvin LAST Gertrude						15. MOTHER'S MAIDEN NAME FIRST Robinson MIDDLE Robinson LAST Robinson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 217-32-8330		17. INFORMANT ADDRESS Alfred L. Reed - Same as Sec. 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.S.C.V.A. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE E. P. Williamson Jr. M.D.				TITLE (SPECIFY) Deputy				DATE SIGNED 12/29/84			
EXAMINER'S NAME (TYPE OR PRINT) E. P. Williamson Jr.				ADDRESS 5550 BALTO NAT'L PK 21228							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-31-1984		23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery		23d. LOCATION CITY OR TOWN Perryville Cecil COUNTY Maryland STATE Maryland			
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Homes P.A. ADDRESS 1630 Edmondson Ave., Catonsville, MD. 21228						25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 9 1 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST JOHN P. RENNER				12-22-84 3:35 PM			
3 SEX MALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6 25 04		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH'S HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b KIND OF BUSINESS OR INDUSTRY Edgewood	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John H. Renner		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine E. Himmer		13e STREET ADDRESS / ZIP CODE 3127 Woodhome Ave. 21234			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 218-22-0019		17. INFORMANT ADDRESS Janice Renner 3127 Woodhome Ave. 21234			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) FRACTURE LEFT FEMUR CUA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: FRACTURE LEFT FEMUR CUA							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 12-13-84 to DEC 22 1984, that (I) (we) lost saw the deceased alive on DEC 22 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Fausto Q. Aguino				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12-22-84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) FAUSTO Q. AGUINO JR				22e ADDRESS 8713 HARTFORD RD. BALTO. 21234			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12-26-84		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME Lassahn Funeral Home				25a DATE REC'D. BY REGISTRAR DEC 27 1984			

13-10-1951

JOHN B. WHITE

WHITE, JOHN B.



CONFIDENTIAL
PROPERTY OF THE
FEDERAL BUREAU OF INVESTIGATION

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 2 9 2
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET BELLE REYNOLDS			2a. DATE OF DEATH MONTH DAY YEAR DEC. 18, 1984		2b. HOUR M M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV 26 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUMMIT NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE FLORIDA		13b. COUNTY SANFORD	13c. CITY OR TOWN SANFORD	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 519 EAST Wt ST. 32711
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM PATTERSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA ANN DINGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 813-09-8849		17. INFORMANT ADDRESS FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Broncho Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James Nolan		DEGREE M.D.		22c. DATE SIGNED 12/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. NOLAN, M.D.		22e. ADDRESS 1 MALLOW HILL ROAD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/21/1984	23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. COUNTY MD.	
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES		ADDRESS 8800 HARFORD RD.		25a. DATE REC'D. BY REGISTRAR DEC 24 1984	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION



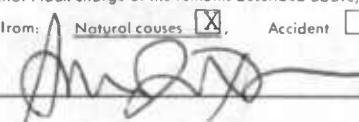
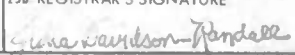
FOR 1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 9 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jannie Rhodes						2a. DATE OF DEATH MONTH DAY YEAR December 1, 1984				2b. HOUR 3:40p.m.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 10 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6016 Belair Rd. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Willie Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Edward James 5246 Nelson Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Occlusion											
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 1, 1984 , to December 1, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 1, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael A. Stang M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/2/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Stang, M.D.				22e. ADDRESS 9000 Franklin Square Drive, 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-7-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR DEC 4 1984		25b. REGISTRAR'S SIGNATURE a Davidson-Randall			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 2 9 4

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST SONIA			MIDDLE RHODES			LAST RHODES			2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY 12 4 19 84			2b. HOUR M 1:58 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9-16-40		6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.		IF UNDER 1 YR MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 4 19 84		7d. HOUR PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier and Business Aid				12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS 21207					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN -----		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3115 North Rolling Road									
14. FATHER'S NAME FIRST MIDDLE LAST Dillard Elmer Bryant, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Muriel Ardmore Small											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 212-40-6683		17. INFORMANT Mr. Eugene Rhodes 21207 3115 North Rolling Road Balto. MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-5-84									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-7-84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Forest MD.							
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.				25. DATE REC'D. BY REGISTRAR DEC 7 1984				25b. REGISTRAR'S SIGNATURE 									
8728 Liberty Road Randallstown, MD. 21133																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

20% COLIC SIBER

WINTER

TO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 2 9 5 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS J RIORDAN				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9, 1984		7b. HOUR 7:00A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 19, 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 4914 Anntana Ave 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Patrick Riordan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Litz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-14-9162		17. INFORMANT ADDRESS Mrs Cleo A Riordan Same As 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary heart dis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 12 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 21, 1960 to 12/9/84 , that (I) (we) last saw the deceased alive on 10/15/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF THE PHYSICIAN'S NAME (TYPE OR PRINT) William Renner M.D.				22c. DEGREE MD		22d. DATES SIGNED 12/11/84	
22e. ADDRESS Union Memorial Hospital Baltimore, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/84		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25. DATE REC'D. BY REGISTRAR 75. REGISTRAR'S SIGNATURE 1984			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove subpages, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is initially injury, or other traumatic event, the medical examiner must use the notes to indicate

IMPORTANT

MEDICAL CERTIFICATION

STATE OF MARYLAND				32296			
DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL W RITTER				2a. DATE OF DEATH MONTH DAY YEAR 12/22/84			
3. SEX FEMALE				4. RACE WHITE			
5. DATE OF BIRTH MONTH DAY YEAR 2/27/1898				6. AGE IN YEARS LAST BIRTHDAY 86			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				8. CITIZEN OF WHAT COUNTRY? USA			
9. BALTIMORE CITY OR COUNTY OF DEATH Towson				10. CITY OR TOWN OF DEATH Towson Md			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			
13a. STATE Md				13b. COUNTY Baltimore			
14. FATHER'S NAME FIRST MIDDLE LAST George C. Wisner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. MA 717 07 6257			
17. INFORMANT ADDRESS Hixson, Tenn.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Colon - DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Bowel DUE TO, OR AS A CONSEQUENCE OF (c) ASD Approximate interval between onset and death 2 wks - years years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
9a. DATE OF OPERATION		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 1974 to Dec 22 19 84, that (I) (we) last saw the deceased alive on Dec 21 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE LAWRENCE BOASND				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L Boasnd				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/84		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home 3631 Falls Rd. 21211				25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

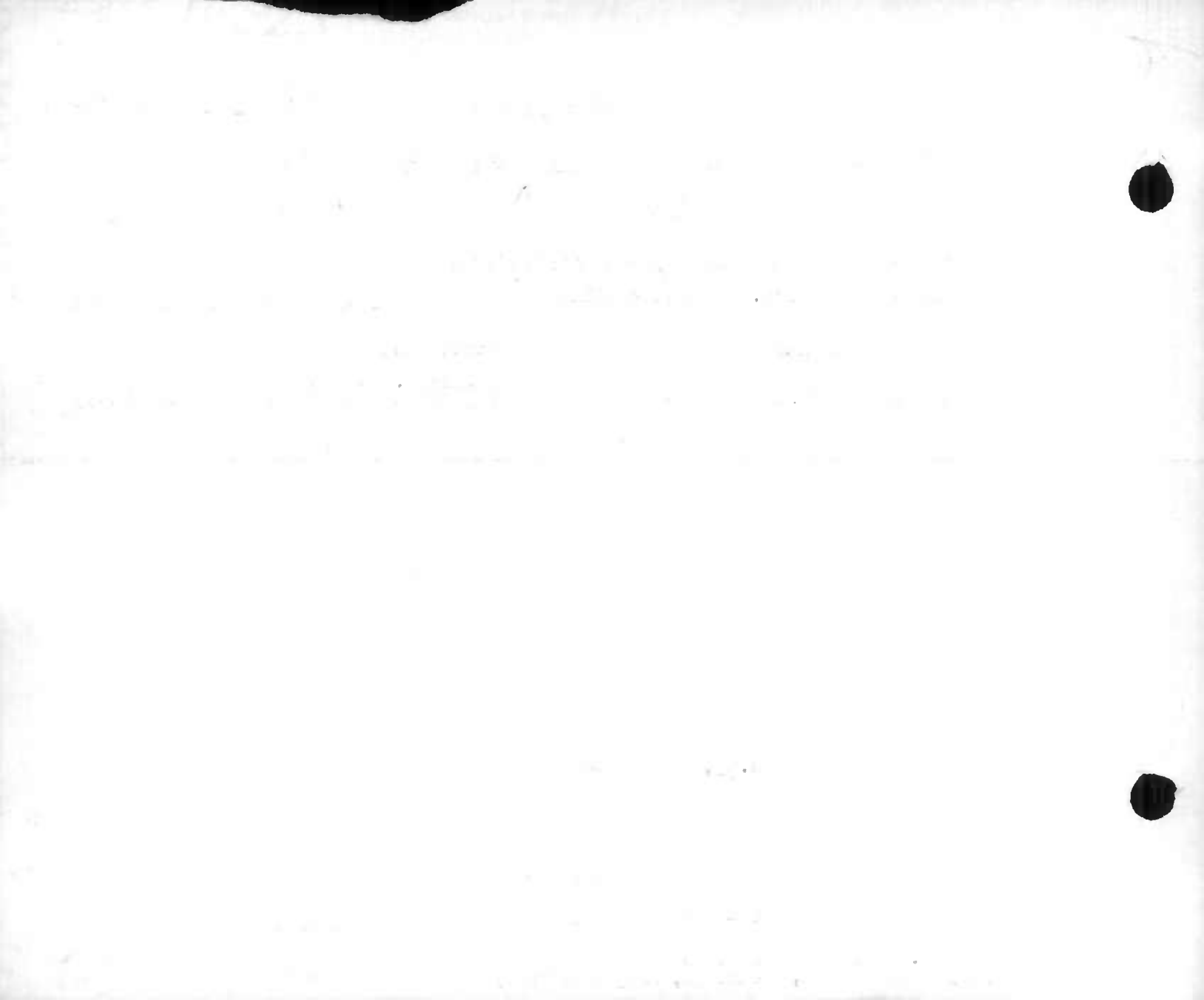
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 9 7
REG. NO.

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MANRICK W. ROBERTS		2a. DATE OF DEATH MONTH DAY YEAR 12 23 84		2b. HOUR 0807 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 26 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md		9. CITIZEN OF WHAT COUNTRY? U.S.A		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD			
12. CITY OR TOWN OF DEATH Balto.		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF PURSUING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE 16b. COUNTY 16c. CITY OR TOWN Maryland Balto. Lutherville		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 2113 Sweetbrier Lane 21093					
19. FATHER'S NAME (FIRST MIDDLE LAST) Winfred Roberts		20. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Gertie Young							
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) WW II Yes		21b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II		22. INFORMANT Phyllis E. Roberts 22a. ADDRESS 2113 Sweetbrier Lane, Baltimore 21093					
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
24a. DATE OF OPERATION		24b. CONDITION FOR WHICH OPERATION WAS PERFORMED				25a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		25b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
26a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> CAUSE OF DEATH		26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
27a. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AL WORK <input type="checkbox"/>		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27c. LOCATION STREET CITY OR TOWN COUNTY STATE					
28. I certify that (1) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (1) (we) last saw the deceased alive on _____ Dec. 23, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) close the body after death.									
29a. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				29b. DATE SIGNED 12-23-84	
30a. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD D. Bressan				30b. ADDRESS 7600 OSWALD DR. 21204					
31a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		31b. DATE 12-26-84		31c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		31d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
32. FUNERAL DIRECTOR Gary N. Kaufman Funeral Home 5695 Main Street, Elkridge, Maryland 21227				33. DATE REC'D. BY REGISTRAR 33a. REGISTRAR'S SIGNATURE DEC 26 1984 Julia Davidson-Randall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 9 8
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>LaVenne E Robinson</u>		MONTH DAY YEAR <u>12 18 1984</u>		8:58 P.M.	
3. SEX <u>Female</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>03 12 1932</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>52</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD		
10. CITY OR TOWN OF DEATH <u>Randallstown</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore General Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>--</u>
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Rockdale</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Benjamin Meyers</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Emma Murphy</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>no</u>		16b. SOCIAL SECURITY NO. <u>213-30-7745</u>		17. INFORMANT ADDRESS <u>Baltimore MD 21207</u> <u>Francis R. Robinson 3414 Meadowdale Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Death</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterial Encephalopathy</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12-15-84</u> <u>12-15-84</u> <u>12-17-84</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Sepsis, Multiple Sclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-17</u> , 19 <u>84</u> , to <u>12-18</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-18</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Allen J. Church M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/18/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen J. Church M.D.</u>		22e. ADDRESS <u>32-6 Stockton II RD 21208</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-21-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cem.</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Timonium Baltimore MD</u>		23e. DATE RECD. BY REGISTRAR <u>DEC 20 1984</u>			
24. FUNERAL DIRECTOR NAME <u>Loring Byers Funeral Directors, Inc.</u>		ADDRESS <u>8728 Liberty Rd. Randallstown, MD 21133</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 9 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACOB ROSENBERG		2a. DATE OF DEATH MONTH DAY YEAR DEC. 22, 1984		2b. HOUR 5:55 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 21, 1903	
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. UNDER 1 YEAR MONTHS DAYS 81 YRS		8. UNDER 24 HRS HOURS MIN. 81 YRS	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MILFORD MANOR NURSING HOME		14. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED		16. KIND OF BUSINESS OR INDUSTRY WATCHMAKER		17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MARYLAND 17b. COUNTY BALTIMORE 17c. CITY OR TOWN BALTIMORE 17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. STREET ADDRESS / ZIP CODE 3809 MIDHEIGHTS RD. #21215		19. FATHER'S NAME FIRST MIDDLE LAST MAX ROSENBERG		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE GALANTA	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		22. SOCIAL SECURITY NO. 216-03-6299		23. INFORMANT WILLIAM ROSENBERG #21133 8903 MEADOW HEIGHTS RD. RANDALLSTOWN, MD	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: prostate carcinoma, CHF, hiatal hernia					
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		27d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27e. LOCATION CITY OR TOWN COUNTY STATE	
27f. I certify that (I) (this hospital) attended the deceased from 10/25/84 to 12/22/84 that (I) (we) lost above (I) (we) (did) (did not) view the body after death.					
27g. SIGNATURE Naomi Cutler MD		27h. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27i. DATE SIGNED 12/22/84	
27j. PHYSICIAN'S NAME (TYPE OR PRINT) NAOMI CUTLER, M.D.		27k. ADDRESS 3640 FORDS LA. BALTO., MD 21215			
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		28b. DATE DEC. 23, 1984		28c. NAME OF CEMETERY OR CREMATORY BETH TFILOH	
28d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		28e. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		28f. DATE REC'D. BY REGISTRAR DEC 28 1984	
28g. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		28h. REGISTRAR'S SIGNATURE John Davidson-Rendell			

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 0 0

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		DECEMBER 14, 1984		2:45AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 2, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.	
10. CITY OR TOWN OF DEATH 21234		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1824 CROMWOOD ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1824 CROMWOOD ROAD 21234	
14. FATHER'S NAME FIRST MIDDLE LAST WALTER ST. GEORGE ROSENSTEEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNA MAY THORNTON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 11 213-16-4402	
17. INFORMANT ADDRESS ELAINE E. PELTZER BORING, MD 21020		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Encephaloma, primary un-</u> DUE TO, OR AS A CONSEQUENCE OF <u>determined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <u>11/17</u> 19 <u>84</u> , to <u>12/14</u> 19 <u>84</u> , that (b) (we) lost the deceased alive on <u>12/10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Luke E. Terry, Jr.</u>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUKE E. TERRY, JR., M.D.		22e. ADDRESS HOWARD COUNTY MEDICAL CENTER 465-7850		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 17, '84		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK BALTIMORE CO., MD		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.		25a. DATE REC'D. BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson Wendell</u>			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 3 0 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HERBERT ALLEN RUDDE										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12 8 19 84	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1 26 35		6. AGE (IN YEARS) 49		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 9 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Dundalk				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1220 Willow Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Disability		12b. KIND OF BUSINESS OR INDUSTRY Gen. Mtrs	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY Balto.		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1220 Willow Rd. 21222			
14. FATHER'S NAME Whitney H. Ruddle						15. MOTHER'S MAIDEN NAME Janie F. Bitzenbarger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1956-1958		17. INFORMANT Dolores J. Ruddle		ADDRESS 1934 Stanhope Rd. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE J. Crossan O'Donovan				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN				ADDRESS 2112 Dundalk Ave., Balto., Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-12-84		23c. NAME OF CEMETERY OR CREMATORY Totten Chapel Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Doe Hill Va.			
24. FUNERAL DIRECTOR NAME Duda-Ruck F.H. 7922 Wise Ave. BaltoMd.						25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					3 2 3 0 2 REG. NO.				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGUERITE M. SACHS					MONTH DAY YEAR 12 11 84				2b. HOUR 1:35 P.M.
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 17 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (IN U.S. OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 3600 LABYRINTH RD. APT F-10 21215		
14. FATHER'S NAME FIRST MIDDLE LAST HARRY MACHT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE JACOBSON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16a. SOCIAL SECURITY NO. 216-01-0482		17. INFORMANT ADDRESS LEW SACHS - 3600 LABYRINTH RD. APT F-10 21215							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 HRS. 6 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) RECENT HIP FRACTURE Amputation									
19a. DATE OF OPERATION 11-27-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DISPLACED (F) HIP FRACTURE			20a. AUTHORIZED BY MEDICAL EXAMINER FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-24-84 to 12-11-84, that (I) (we) last saw the deceased alive on 12-11-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Tasneem Lakhan				DEGREE (a) ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TASNEEM LAKHAN				22e. ADDRESS 5401 OLD COURT RD, RANDALLSTOWN MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 14/84		23c. NAME OF CEMETERY OR CREMATORY HARSHAN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD 21132			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & SONS INC.				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Shirley Davidson-Randall			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32303					
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Myrtle Virginia SALVO								December 8, 1984				2:25a M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS (LAST BIRTHDAY))				7. UNDER 1 YEAR	
F		W		MONTH DAY YEAR 2/23/21				63 YRS.				MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
MD.		USA						Baltimore County				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
ROSSVILLE		FRANKLIN SQ. HOSP		H.S.W.E									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MD.		BALTO		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1818 MADLEBOROUGH RD				21221	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST HENRY F. VOGEL				FIRST MIDDLE LAST MABEL BROUGHTON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS					
NO		216-24382		GARY SALVO				11509 PULASKI HWY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Septic Shock													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) Upper Gastrointestinal Bleeding													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Metastatic Carcinoma of the lung													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION					
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK AT WORK								STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from December 5, 1984, to December 8, 1984, that (we) last saw the deceased alive on December 8, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (do) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
Albert K. Lee M.D.								12-8-84.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
Albert K. Lee, M.D.				9000 Franklin Square Drive, 21237									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				12/11/84		OAK LAWN				CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
J.G. CONNELLY SONS 300 MACE				DEC 12 1984									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 0 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rene Francois SANDEAU SR.			2a. DATE OF DEATH MONTH DAY YEAR December 21, 1984			2b. HOUR 7:10P M					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/15/06		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 344 STILLWATER 21221		
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 197-01-047		17. INFORMANT SARAH SANDEAU				ADDRESS ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole DUE TO, OR AS A CONSEQUENCE OF (b) General System Failure: Cancer of the Bladder, Left Lower Lobe Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from December 3, 1984, to December 21, 1984, that (I) (we) last saw the deceased alive on December 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body of the death.											
22b. SIGNATURE Alberto A. Borges						DEGREE MD		22c. DATE SIGNED 12/21/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alberto A. Borges						22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/24/84		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY						25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall			

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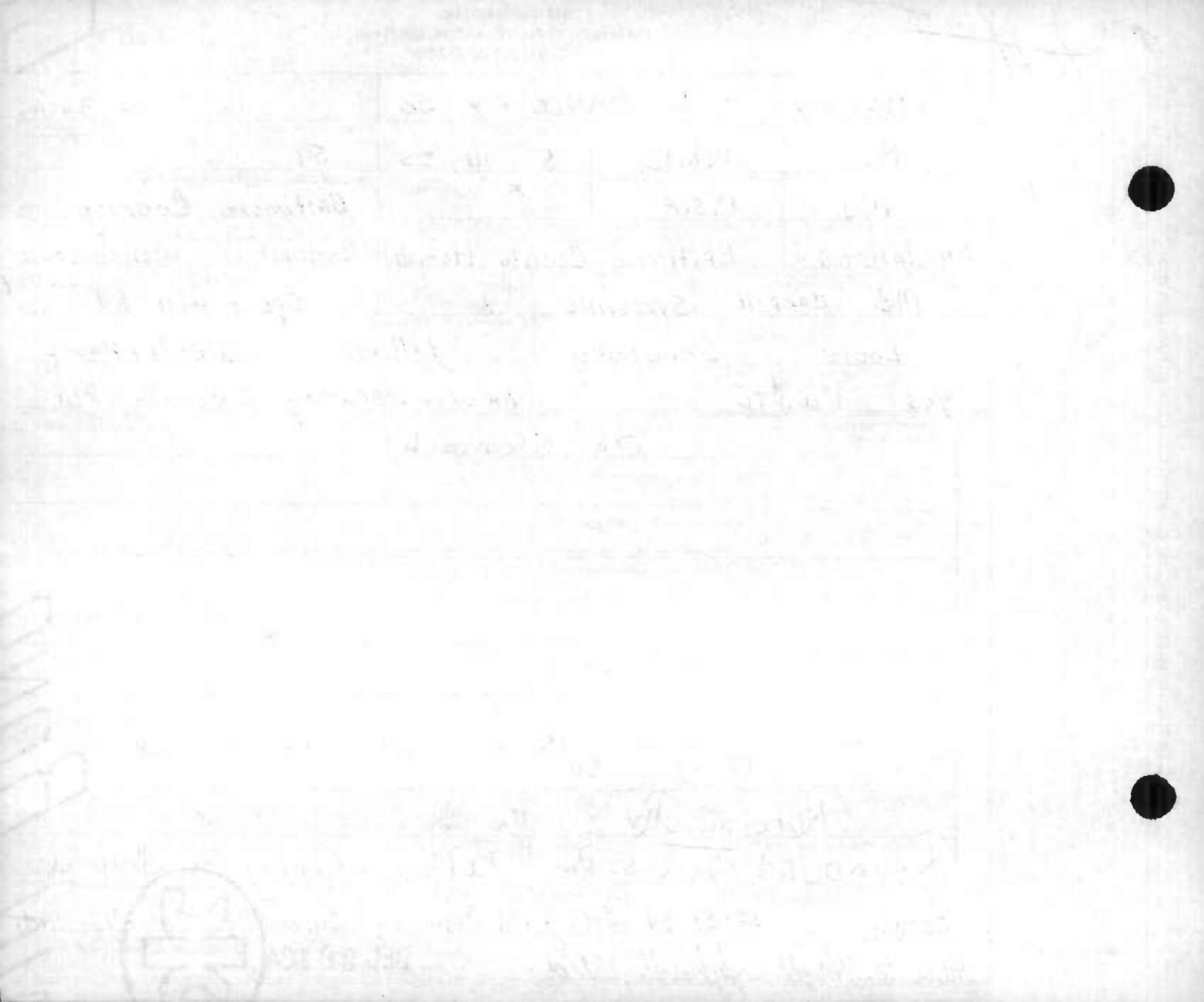


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 0 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY L SANDOSKY SR.										2a. DATE OF DEATH MONTH DAY YEAR 12. 27 84				2b. HOUR 3:45AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 14 25		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59		7. UNDER 1 YEAR MONTHS DAYS 0 0		7. UNDER 24 HRS. HOURS MIN. 0 0					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.									
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Construction							
13a. STATE Md.				13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Spout Hill Rd. 21784					
14. FATHER'S NAME FIRST MIDDLE LAST Louis Sandosky				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Westenkamp											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WWTL		17. INFORMANT ADDRESS Kaloria Sandosky Sykesville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA. Stomach										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12. 20 19 84 to 12. 27 19 84 , that (I) (we) lost saw the deceased alive on 12. 27 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Rayadurg Govinda Rao				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYADURG GOVINDA RAO				22e. ADDRESS Baltimore County GNL Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.							
24. FUNERAL DIRECTOR NAME Harry W. Haight Sykesville, Md.						25a. DAY REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 28 1984									

MEDICAL CERTIFICATION



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 0 6 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Evelyn M SAUER		2a. DATE OF DEATH MONTH DAY YEAR Dec. 23, 1984			2b. HOUR 3 ¹¹ M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 17, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co., MD.					
10. CITY OR TOWN OF DEATH Overlea		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13 E. Elm Avenue 21206				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker			12b. KIND OF BUSINESS OR INDUSTRY -----		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Overlea		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13 E. Elm Avenue 21206			
14. FATHER'S NAME FIRST MIDDLE LAST John C. Lennon					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Griffin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-46-6440		17. INFORMANT ADDRESS John Sauer 13 E. Elm Ave 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Deceased</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Revealed as a Heart - Diabetes Mellitus NID - Seizures.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>F-5</u> , 19 <u>63</u> , to <u>12-23</u> , 19 <u>84</u> , that (we) lost saw the deceased alive on <u>12-22-84</u> , 19 <u>84</u> , and that in (my) () opinion death occurred on the date and hour and from the causes stated above. (I) () did () view the body after death.											
22b. SIGNATURE <u>John C. Hyle</u>				DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Dec 24, 84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Hyle, M.D.				22e. ADDRESS 7527 Belair Rd. Balto. Md. 21236							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 27, 84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.				
24. FUNERAL DIRECTOR NAME Doppel Funeral Homes, Inc.		ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 26 1984			25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>				

BP

(a)

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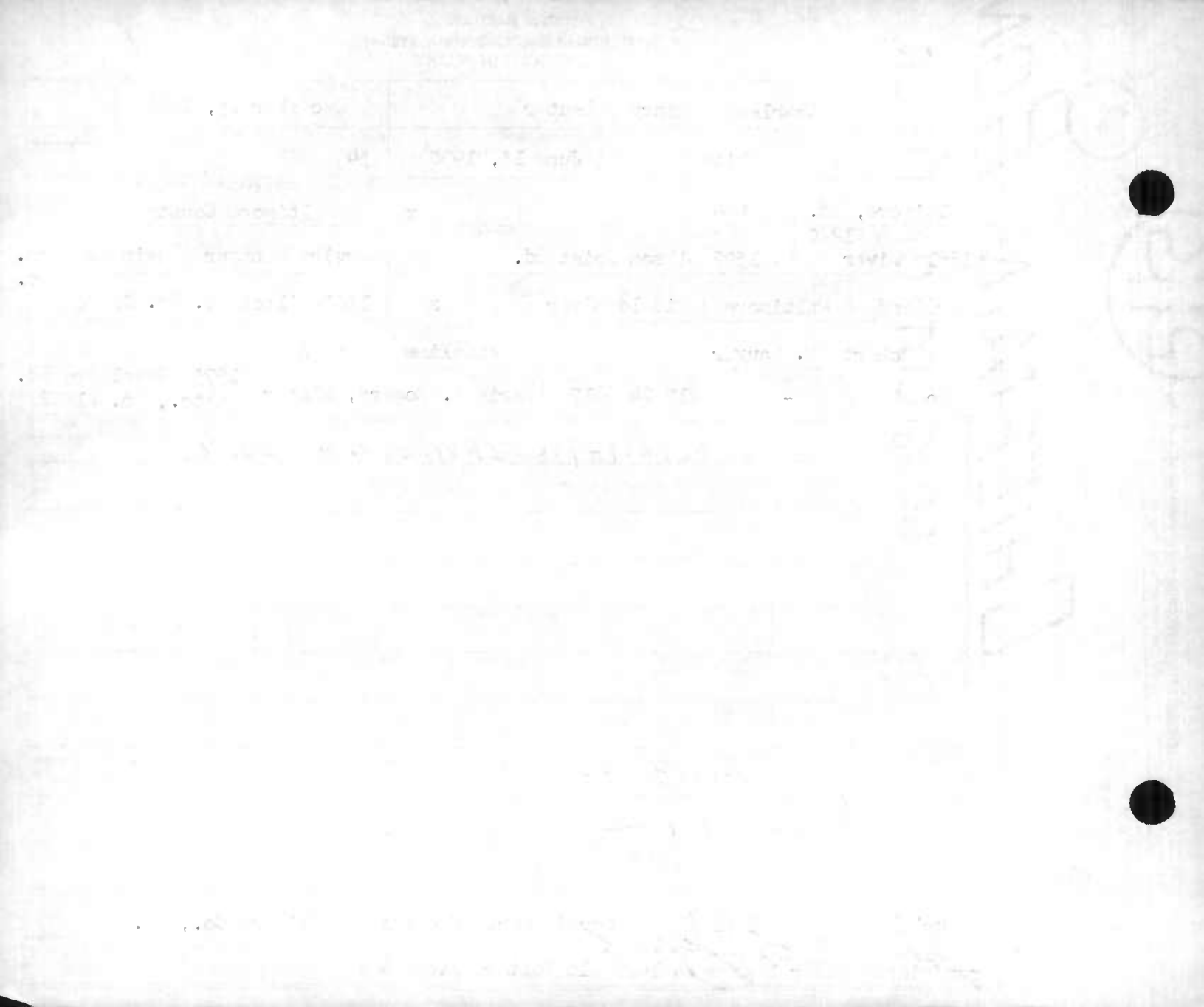
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 0 7

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Henry Sauter			2a. DATE OF DEATH MONTH DAY YEAR December 15, 1984		2b. HOUR M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 15, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 54	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Middle River	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1507 Wilson Point Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Manager		12b. KIND OF BUSINESS OR INDUSTRY Business Mach. Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	
14. FATHER'S NAME FIRST MIDDLE LAST Robert H. Sauter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madaline Hagan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 24 9417		17. INFORMANT ADDRESS Marie T. Rogers, Sister 1975 Haselmere Rd. Balto., Md. 21222	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. E. PARRA, M.D. 7122 HILMOLD ROAD		22c. DATE SIGNED		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			
23b. DATE 12/18/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR Brazdzinski Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

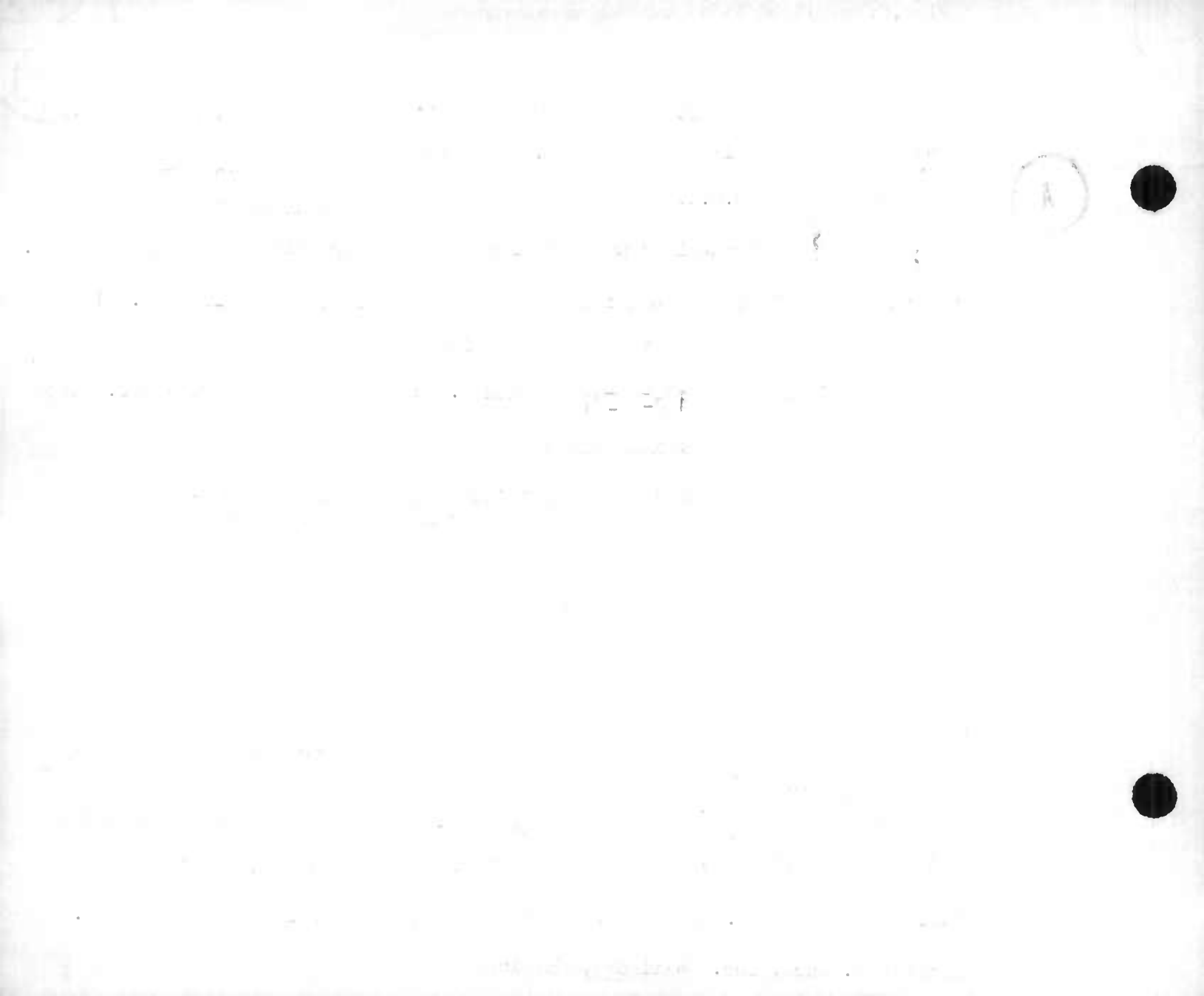


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 3 0 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Arthur SCHAFER Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 3, 1984		2b. HOUR 7:00PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 6 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Western Elec.	
13a. STATE Maryland			13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 3417 Putty Hill Ave. 21234
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Schafer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mina Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1		17. INFORMANT ADDRESS Ruth P. Schafer 3417 Putty Hill Ave. 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro-vascular Accident (Right Frontotem- poral Hemorrhagic Infarct) DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that Albert A. Berger attended the deceased from November 23, 1984 to December 3, 1984 , that he (we) last saw the deceased alive on December 3, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE OF PHYSICIAN Albert A. Berger		DEGREE MD		22c. DATE SIGNED 12/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert A. Berger		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 7, 1984	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE Carla Anderson-Rodgers	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 0 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST WILLIAM F. SCHAFFER			2a. DATE OF DEATH MONTH DAY YEAR 12/ 26/ 84			2b. HOUR 6:20A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 16 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman		12b. KIND OF BUSINESS OR INDUSTRY Balto. City			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 905 Dalton Avenue 21224		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Joseph Schaffer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Gram							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT Annette L. Appel		ADDRESS 603 Delaware Ave. Balto., MD. 21221			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SECONDARY TO CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) </div>										<u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 IS PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> , 19 <u>82</u> , to <u>12/26</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Theodore Patterson M.D.</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. THEODORE PATTERSON						22e. ADDRESS 284-5210 DUNDALK AVE. 3427, DUNDALK, MD 21222					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS DUDA RUCK-WISE AVE., DUNDALK, MARYLAND						25a. DATE REC'D. BY REGISTRAR DEC 31 1984			25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 1 0
REG. NO.

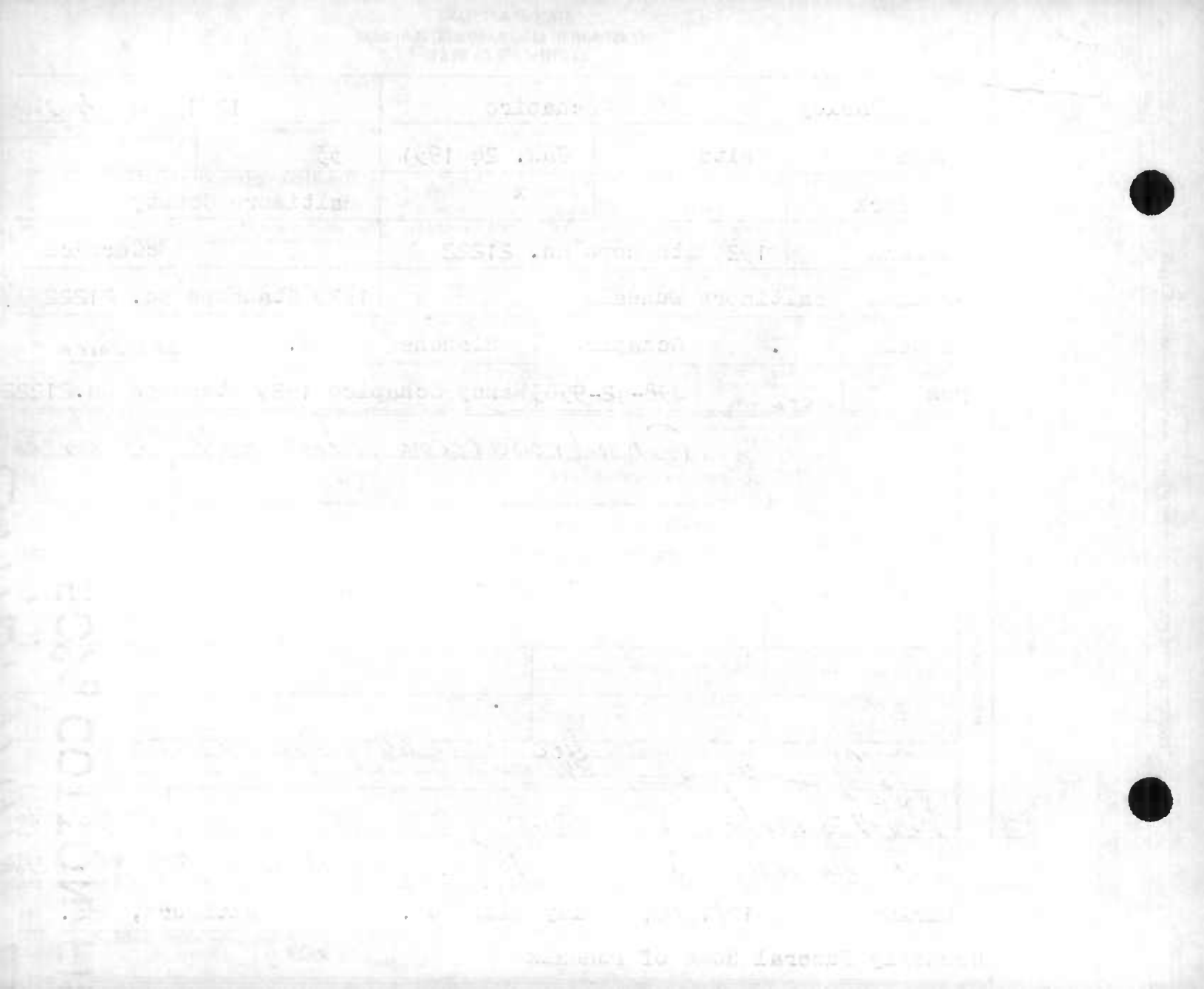
1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harley Schapiro			2a. DATE OF DEATH MONTH DAY YEAR 12/15/84		2b. HOUR 4 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24 1951		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1929 Stanhope Rd. 21222				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) McCormick	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel K. Schapiro		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche S. SHWEDICK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes VIETNAM		16b. SOCIAL SECURITY NO. 098-42-9583		17. INFORMANT ADDRESS Nancy Schapiro 1929 Stanhope Rd. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chondrosarcoma, chest wall DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) History of "cured" Hodgkins Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from Dec 6 19 84 to Dec 15 19 84 , that (we) lost saw the deceased alive on Dec 15 19 84 , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.							
22b. SIGNATURE W.B. Daniels, Jr.				DEGREE M.D.		22c. DATE SIGNED 12/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.B. Daniels, Jr.				22e. ADDRESS Hospice, Union Memorial Hospital 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR Connelly Funeral Home of Dundalk				25a. DATE REC'D. BY REGISTRAR DEC 19 1984			
				25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 1 1
REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) AUGUSTINA SCHEIDT			2a. DATE OF DEATH MONTH DAY YEAR 12 26 84			2b. HOUR 750 A				
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 18 90		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.				
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Rossville				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 102 Linhigh Ave. 21236	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK Gottschalk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Schleiker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 213-74-9735		17. INFORMANT G. Ormond Skuhr				ADDRESS 213 Linhigh Ave. 21236	

18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Acute Pulmonary edema.

ascvd atrial fibrillation

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
few hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

s/p. C-V-A with Rt hemiplegia.

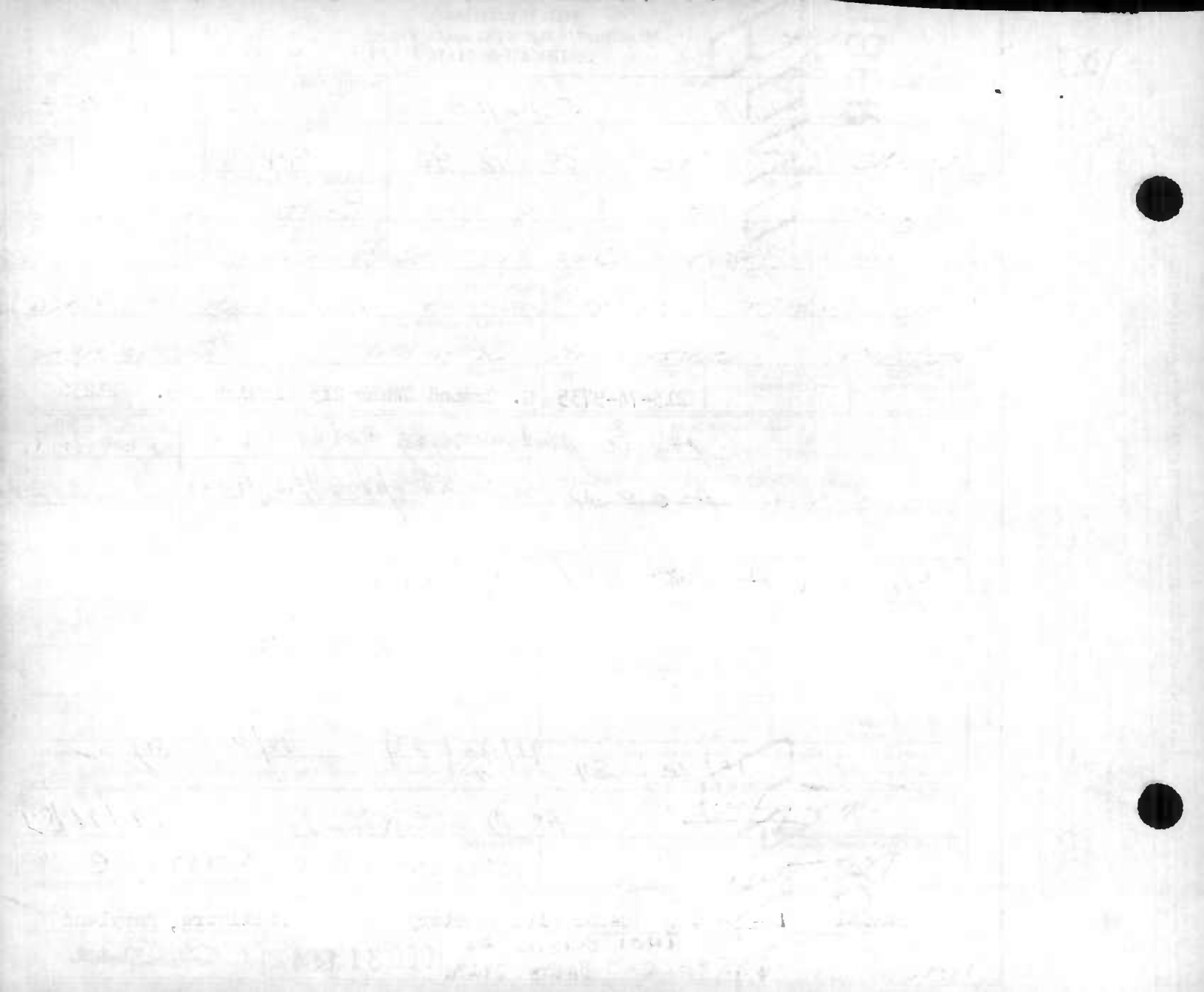
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/26/84 to 12/26/84 , that (I/we) last saw the deceased alive on 12/26/84 , and that (I/we) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Tun		22e. ADDRESS Manor care Rossville.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME hassahn		ADDRESS 665-2000 BALTO. 21236		25. DATE REC'D BY REGISTRAR DEC 31 1984		REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 1 2 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		M		
		JOSEPH E. SCHENE					December 8, 1984						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		White		May 18, 1928			56 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.					Baltimore County MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Catonsville		1316 Brook Road			Retired - Policeman-Balt. CO.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1316 Brook Road 21228					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John Schene				Etta Boswell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
Yes		Korean		214-26-9918		Betty Lou Schene Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malignant melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <u>JUNE 15, 19 84</u> to <u>DEC 8, 19 84</u> that (I) (we) lost saw the deceased alive on <u>AUG 10, 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Paul E. Gormley</u> MD		22c. DATE SIGNED <u>12/10/84</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
PAUL E. GORMLEY		900 CATON AVE BALTO. MD 21229											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		12/12/84		New Cathedral Cemetery			Baltimore MD						
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228													
25a. DATE REC'D BY REG. <u>DEC 12 1984</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>													

MEDICAL CERTIFICATION

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

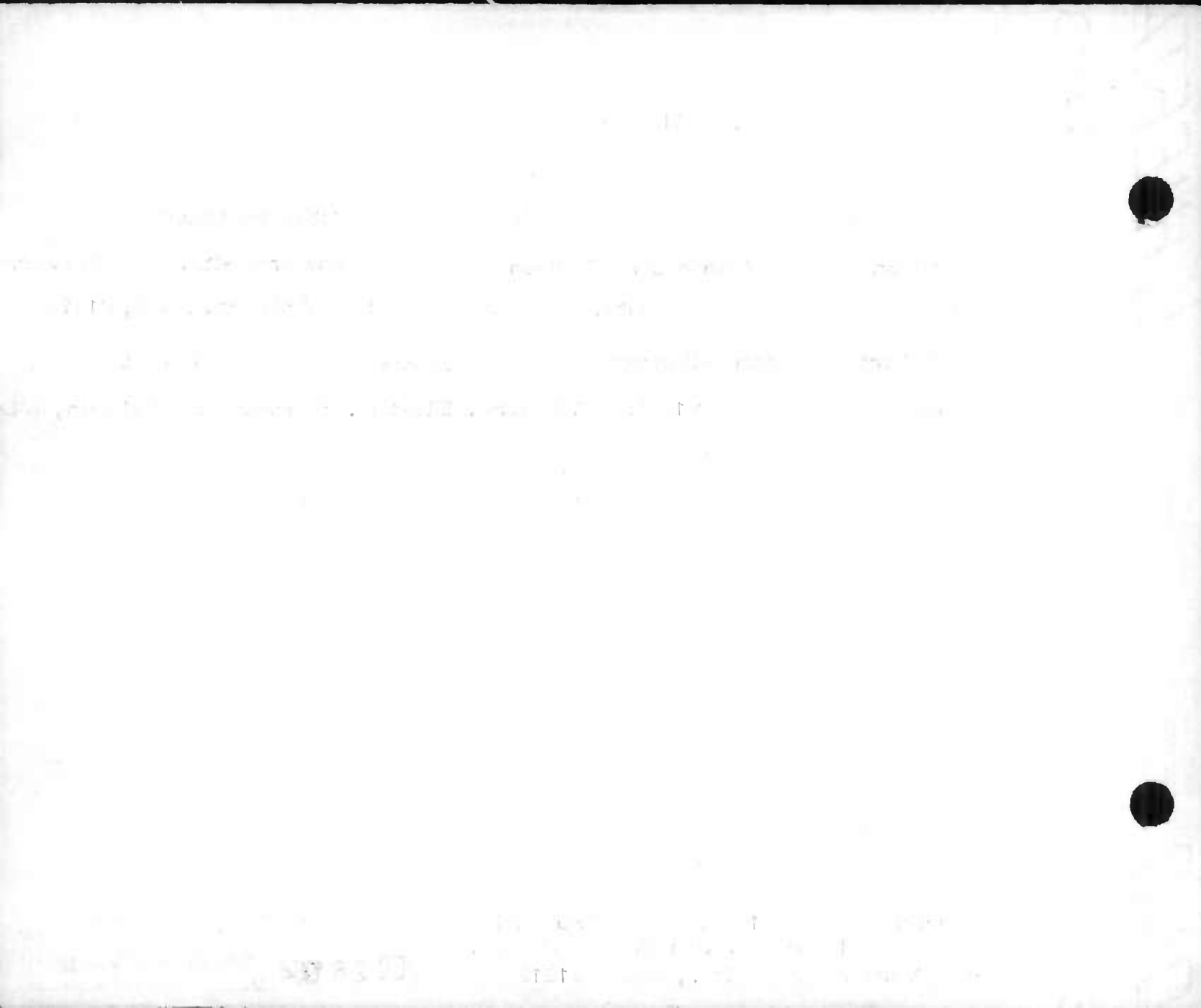
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				- 3 2 3 1 3			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert E. SCHMELLENKAMP				2a. DATE OF DEATH MONTH DAY YEAR December 23 1984		2b. HOUR 10 P M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Towson		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager-Balto.		12b. KIND OF BUSINESS OR INDUSTRY Gas & Electric	
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1528 Ralworth Road, 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Schmellenkamp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Lamkin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 05 6675		17. INFORMANT ADDRESS Mrs. Ellen R. Sauerbrey, Baldwin, MD			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Jeans</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>20 Dec</u> 19 <u>84</u> to <u>23 Dec</u> 19 <u>84</u> , that (I) <u>did not</u> saw the deceased alive on <u>23 Dec</u> 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.							
22b. SIGNATURE <u>Walter T. Kees</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>23 Dec 1984</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Walter T. Kees</u>				22e. ADDRESS <u>Monkton Md 21111</u>			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD	
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				25a. DATE REC'D. BY REGISTRAR <u>DEC 26 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 1 4

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FREDERICK W SCHMELTZER			2a. DATE OF DEATH MONTH 12 DAY 15 YEAR 84			2b. HOUR 6.34A					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 10 YEAR 69		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSP. 7620 YORK RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Balto. Co. Public			12b. KIND OF BUSINESS OR INDUSTRY School-Engineer		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9923 HARFORD Rd 21234			
14. FATHER'S NAME FIRST Unknown MIDDLE LAST Schmeltzer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE UNKNOWN LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 207-05-7796		17. INFORMANT NAME Mrs. Elizabeth S. Schmeltzer Same as # 13e ADDRESS 					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA AND EMPHYSEMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION 12.5.84				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA R-LUNG.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (I) (this hospital) attended the deceased from 12.4 , 19 84 , to 12.15 , 19 84 , that (I) (we) lost saw the deceased alive on 12.15 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jose T. Villa Jr.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOPE T. VILLA JR.						22e. ADDRESS 7600 OSLER DRIVE, TOWSON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-17-84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE 			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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FREDERICK S. SMITH

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 1 5
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edna A. Schneeman			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1984			2b. HOUR 4:20PM _M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 25, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Harken, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					
13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 419 Sherwood Road 21030	
14. FATHER'S NAME FIRST MIDDLE LAST William J. Harrison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Wales			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-4403		17. INFORMANT ADDRESS Fred W. Schneeman, Jr. - Same as Sec. 13			

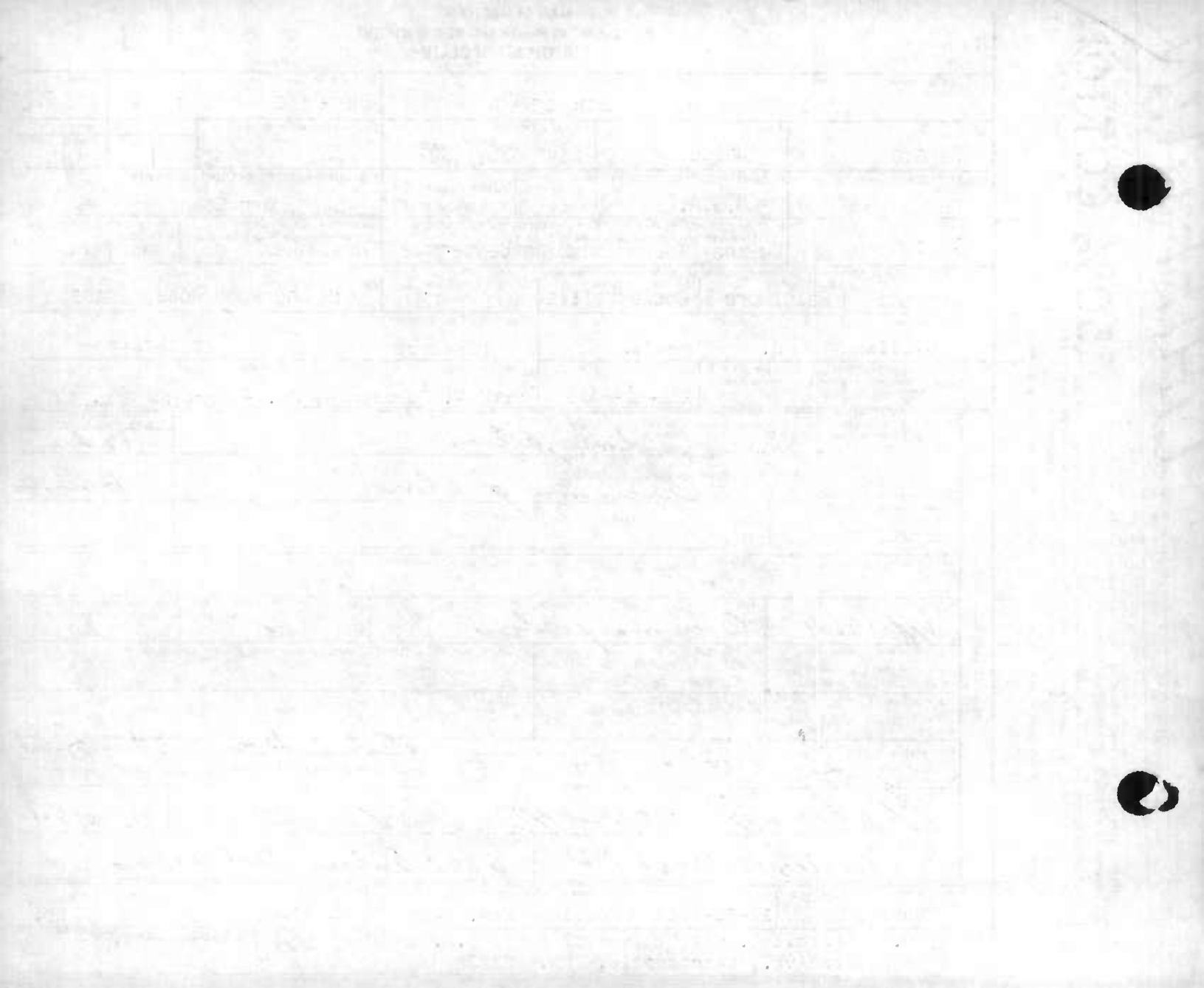
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>6 months</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION <u>Sept 1984</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of colon</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>Dec</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Nov 30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Charles M. Kerr MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-10-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Kerr MD				22e. ADDRESS 6801 Belair Rd 21206			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-12-1984		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.	
24. FUNERAL DIRECTOR NAME L. M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Ave., Catonsville, MD. 21228				25a. DATE RECD BY REGISTRY DEC 11 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 1 6
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		December 4, 1984		2: 55p ^m	
3. SEX Anna Belle		4. RACE SCNEIDER		5. DATE OF BIRTH	
FEMALE		CAUCASIAN		MONTH DAY YEAR	
		08 09 1899		85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MARYLAND		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
ROSSVILLE		FRANKLIN SQUARE HOSPITAL		Baltimore County MD. HOUSEWIFE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		BALTIMORE		ROSEDALE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
ADAM GREBNER		LOUISE		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		17a. STREET ADDRESS / ZIP CODE	
214741472		ROY SCHNEIDER 510 PENNY LANE		7604 WILHELM AVE. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Probable Cardiac Arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Chronic obstructive Pulmonary disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from, January 7, 1984, to November 13, 1984, that (we) last saw the deceased alive on November 13, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Phyllis M. Chappell, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Phyllis M Chappell M.D.		9000 Franklin Square Drive, Balt. 21237			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		12/07/84		DULANEY VALLEY	
24. FUNERAL DIRECTOR NAME		24a. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
J. J. [Signature]		124 Chesapeake Ave		12-12-84	
				25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 1 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE H. SCHREIBER Sr			2a. DATE OF DEATH MONTH DECEMBER DAY 3 YEAR 1984			2b. HOUR 1:15 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Jan. DAY 25 YEAR 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OR GIVE MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2008 Taylor Ave. 21234		
14. FATHER'S NAME FIRST George MIDDLE P. LAST Schreiber			15. MOTHER'S MAIDEN NAME FIRST Christina MIDDLE Wilhelm LAST Wilhelm								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-1130		17. INFORMANT ADDRESS Mary B. Schreiber 2008 Taylor Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR DUE TO, OR AS A CONSEQUENCE OF (b) THROMBOSIS & STROKE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		STATE	
22. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 84 , to 12-3 , 19 84 , that (I) (we) last saw the deceased alive on 12-3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE AH Ghiladi			DEGREE			22c. DATE SIGNED 12-3-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AH GHILADI, MD.			22e. ADDRESS 7600 OSLER Dr. TOWSON								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE Maryland				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md. ADDRESS 						25a. DATE REC'D. BY REGISTRAR DEC 3 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified for autopsy.

BP

1997, 2000, 2002, 2004, 2006, 2008, 2010, 2012, 2014, 2016, 2018, 2020, 2022, 2024, 2026, 2028, 2030, 2032, 2034, 2036, 2038, 2040, 2042, 2044, 2046, 2048, 2050, 2052, 2054, 2056, 2058, 2060, 2062, 2064, 2066, 2068, 2070, 2072, 2074, 2076, 2078, 2080, 2082, 2084, 2086, 2088, 2090, 2092, 2094, 2096, 2098, 2100, 2102, 2104, 2106, 2108, 2110, 2112, 2114, 2116, 2118, 2120, 2122, 2124, 2126, 2128, 2130, 2132, 2134, 2136, 2138, 2140, 2142, 2144, 2146, 2148, 2150, 2152, 2154, 2156, 2158, 2160, 2162, 2164, 2166, 2168, 2170, 2172, 2174, 2176, 2178, 2180, 2182, 2184, 2186, 2188, 2190, 2192, 2194, 2196, 2198, 2200, 2202, 2204, 2206, 2208, 2210, 2212, 2214, 2216, 2218, 2220, 2222, 2224, 2226, 2228, 2230, 2232, 2234, 2236, 2238, 2240, 2242, 2244, 2246, 2248, 2250, 2252, 2254, 2256, 2258, 2260, 2262, 2264, 2266, 2268, 2270, 2272, 2274, 2276, 2278, 2280, 2282, 2284, 2286, 2288, 2290, 2292, 2294, 2296, 2298, 2300, 2302, 2304, 2306, 2308, 2310, 2312, 2314, 2316, 2318, 2320, 2322, 2324, 2326, 2328, 2330, 2332, 2334, 2336, 2338, 2340, 2342, 2344, 2346, 2348, 2350, 2352, 2354, 2356, 2358, 2360, 2362, 2364, 2366, 2368, 2370, 2372, 2374, 2376, 2378, 2380, 2382, 2384, 2386, 2388, 2390, 2392, 2394, 2396, 2398, 2400, 2402, 2404, 2406, 2408, 2410, 2412, 2414, 2416, 2418, 2420, 2422, 2424, 2426, 2428, 2430, 2432, 2434, 2436, 2438, 2440, 2442, 2444, 2446, 2448, 2450, 2452, 2454, 2456, 2458, 2460, 2462, 2464, 2466, 2468, 2470, 2472, 2474, 2476, 2478, 2480, 2482, 2484, 2486, 2488, 2490, 2492, 2494, 2496, 2498, 2500, 2502, 2504, 2506, 2508, 2510, 2512, 2514, 2516, 2518, 2520, 2522, 2524, 2526, 2528, 2530, 2532, 2534, 2536, 2538, 2540, 2542, 2544, 2546, 2548, 2550, 2552, 2554, 2556, 2558, 2560, 2562, 2564, 2566, 2568, 2570, 2572, 2574, 2576, 2578, 2580, 2582, 2584, 2586, 2588, 2590, 2592, 2594, 2596, 2598, 2600, 2602, 2604, 2606, 2608, 2610, 2612, 2614, 2616, 2618, 2620, 2622, 2624, 2626, 2628, 2630, 2632, 2634, 2636, 2638, 2640, 2642, 2644, 2646, 2648, 2650, 2652, 2654, 2656, 2658, 2660, 2662, 2664, 2666, 2668, 2670, 2672, 2674, 2676, 2678, 2680, 2682, 2684, 2686, 2688, 2690, 2692, 2694, 2696, 2698, 2700, 2702, 2704, 2706, 2708, 2710, 2712, 2714, 2716, 2718, 2720, 2722, 2724, 2726, 2728, 2730, 2732, 2734, 2736, 2738, 2740, 2742, 2744, 2746, 2748, 2750, 2752, 2754, 2756, 2758, 2760, 2762, 2764, 2766, 2768, 2770, 2772, 2774, 2776, 2778, 2780, 2782, 2784, 2786, 2788, 2790, 2792, 2794, 2796, 2798, 2800, 2802, 2804, 2806, 2808, 2810, 2812, 2814, 2816, 2818, 2820, 2822, 2824, 2826, 2828, 2830, 2832, 2834, 2836, 2838, 2840, 2842, 2844, 2846, 2848, 2850, 2852, 2854, 2856, 2858, 2860, 2862, 2864, 2866, 2868, 2870, 2872, 2874, 2876, 2878, 2880, 2882, 2884, 2886, 2888, 2890, 2892, 2894, 2896, 2898, 2900, 2902, 2904, 2906, 2908, 2910, 2912, 2914, 2916, 2918, 2920, 2922, 2924, 2926, 2928, 2930, 2932, 2934, 2936, 2938, 2940, 2942, 2944, 2946, 2948, 2950, 2952, 2954, 2956, 2958, 2960, 2962, 2964, 2966, 2968, 2970, 2972, 2974, 2976, 2978, 2980, 2982, 2984, 2986, 2988, 2990, 2992, 2994, 2996, 2998, 3000, 3002, 3004, 3006, 3008, 3010, 3012, 3014, 3016, 3018, 3020, 3022, 3024, 3026, 3028, 3030, 3032, 3034, 3036, 3038, 3040, 3042, 3044, 3046, 3048, 3050, 3052, 3054, 3056, 3058, 3060, 3062, 3064, 3066, 3068, 3070, 3072, 3074, 3076, 3078, 3080, 3082, 3084, 3086, 3088, 3090, 3092, 3094, 3096, 3098, 3100, 3102, 3104, 3106, 3108, 3110, 3112, 3114, 3116, 3118, 3120, 3122, 3124, 3126, 3128, 3130, 3132, 3134, 3136, 3138, 3140, 3142, 3144, 3146, 3148, 3150, 3152, 3154, 3156, 3158, 3160, 3162, 3164, 3166, 3168, 3170, 3172, 3174, 3176, 3178, 3180, 3182, 3184, 3186, 3188, 3190, 3192, 3194, 3196, 3198, 3200, 3202, 3204, 3206, 3208, 3210, 3212, 3214, 3216, 3218, 3220, 3222, 3224, 3226, 3228, 3230, 3232, 3234, 3236, 3238, 3240, 3242, 3244, 3246, 3248, 3250, 3252, 3254, 3256, 3258, 3260, 3262, 3264, 3266, 3268, 3270, 3272, 3274, 3276, 3278, 3280, 3282, 3284, 3286, 3288, 3290, 3292, 3294, 3296, 3298, 3300, 3302, 3304, 3306, 3308, 3310, 3312, 3314, 3316, 3318, 3320, 3322, 3324, 3326, 3328, 3330, 3332, 3334, 3336, 3338, 3340, 3342, 3344, 3346, 3348, 3350, 3352, 3354, 3356, 3358, 3360, 33

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Chen, L.

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et al. 1985)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed into 122 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 1 8	
1 - STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
JAMES H. SCHUMACHER SR.					12 28 84					10:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.			
M	W	8 MONTH 17 14		70		MONTHS DAYS		HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	USA			BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
TOWSON	GBMC 6701 N. CHARLES STR		Supervisor		Western Electric						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE				
Virginia Northumber				Farnham			Box 366A 22460		9999		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Frederick Schumacher		Anna Lance									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		215-10-4166		Marion E. Schumacher		Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE VASCULAR INSUFFICIENCY WITH DUE TO, OR AS A CONSEQUENCE OF, PARAPLEGIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/05 19 84, to 12/28 19 84, that (I) (we) last saw the deceased alive on 12/28 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>S. Girdhar</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/28/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
DR. SARVA P. GIRDHAR		GBMC									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12/31/84		Farnham Baptist Church		Farnham, Northumber, Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212		JAN 2 1985		<i>[Signature]</i>							

10:15

CONTRACTOR

DATE

CLINTON COUNTY

GEORGE W. CHASE

NOV 1901

BEVERLY VASCULAR DISORDER WITH
PARALYSIS

12/10/01 12/10/01 12/10/01

12/10/01 12/10/01 12/10/01

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 3 1 9			
1. DECEASED NAME (TYPE OR PRINT) JULES K. SCHWARTZ				2a. DATE OF DEATH MONTH DAY YEAR 12-13-84 8:44 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary		7b. CITIZEN OF WHAT COUNTRY? Hungary		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician - Retired		12b. KIND OF BUSINESS OR INDUSTRY Band	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Towson	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 11 E. Chesapeake Ave. 21204			
14. FATHER'S NAME FIRST MIDDLE LAST Louis Schwartz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Petrovich			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-60-1497		17. INFORMANT ADDRESS Vera M.E. Attar-1204 Stevenson La. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: DIABETES MELLITUS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 12-9 , 19 84 , to 12-13 , 19 84 , that (we) lost saw the deceased alive on 12-13 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jorge C. Secada-Lovio, MD				DEGREE MD		22c. DATE SIGNED 12-13-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE C. SECADA-LOVIO, MD				22e. ADDRESS ST. JOSEPH HOSPITAL 7620 YORK RD. TOWSON, MD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Handall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 2 3 2 0		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) JOSEPH John SCLAFANI, Sr.				2a. DATE OF DEATH December 31 1984		2b. HOUR 9:58A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 16 1921		6. AGE (IN YEARS (LAST BIRTHDAY)) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Agent		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 915 Wampler Lane, 21157	
14. FATHER'S NAME Peter Paul Sclafani				15. MOTHER'S MAIDEN NAME Mary Minacapolli					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 218-07-1800		17. INFORMANT ADDRESS Doris L. Sclafani, 915 Wampler Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive and Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 19, 1984, to Dec 31, 1984, that (I) (we) last saw the deceased alive on Dec 31, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John E. Adams, M.D.				22c. DATE SIGNED Dec. 31, 1984				22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Adams, M.D.				22f. ADDRESS 6701 N. Charles Street, Towson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/85		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Forest Balto. Md.			
24. FUNERAL DIRECTOR NAME Martin D. Lawson				25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE C. E. Anderson			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours in the office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be reviewed at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 3 2 1

1. DECEASED NAME (TYPE OR PRINT) Virgie V. SHEETS			2a. DATE OF DEATH MONTH DAY YEAR December 25, 1984			2b. HOUR 5:45A M			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8/16/24		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KY		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWF		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN MIDDLE RIVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1609 WILSON PT. RD 21220	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES PENSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE MAE CARTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-1167		17. INFORMANT ADDRESS ROBERT SHEETS 228 SHAGBARK RD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Bilateral Cerebrovascular Thrombotic Strokes									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 21, 1984, to December 25, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 25, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE Julio Schwartzman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julio Schwartzman M.D.				22e. ADDRESS 9000 Franklin Square Dr. 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 3 2 2
REG. NO.

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR																	
1. DECEASED NAME (TYPE OR PRINT) Misty D. Sheetz										MONTH DAY YEAR 12-28 1984		M 10:45 a.m.																	
3. SEX Female		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) Nov. 21, 1984		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 38		IF UNDER 1 YR. MONTHS DAYS 38		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12-28 1984		2d. HOUR 10:45 a.m.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD																	
10. CITY OR TOWN OF DEATH Woodstock				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2803 Hernwood Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none				12b. KIND OF BUSINESS OR INDUSTRY none																	
13a. STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 125 Grand Ave. 21502													
14. FATHER'S NAME (FIRST MIDDLE LAST) Jerry Dean Golden										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Tina Eileen Grogg																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no										16b. SOCIAL SECURITY NO. none										17. INFORMANT ADDRESS Mrs. Tina Sheetz, Cumberland, Md. Mother									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE Dennis F. Smyth				TITLE (SPECIFY) Assistant				M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 12-29-84													
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-31-84				23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.																	
24. FUNERAL DIRECTOR NAME James F. Scarpelli				ADDRESS Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR JAN 3 1985				25b. REGISTRAR'S SIGNATURE Julia E. ...																	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 2 3
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCIS T. SIGWART, SR.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16, 1984			2b. HOUR 12 A. M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 28, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH PARKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3038 MARSHLAND AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FINISHER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND 13c. COUNTY BALTIMORE 13d. CITY OR TOWN PARKVILLE					13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 3038 MARSHLAND AVE. 21234		
14. FATHER'S NAME FIRST MIDDLE LAST JACOB SIGWART				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMMIE BACKAUS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218 012483		17. INFORMANT ADDRESS FAMILY RECORDS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-23 19 82 to 12-16 19 84 , that (I) (was) lost saw the deceased alive on 11-13 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (would) (did not) view the body after death.							
22b. SIGNATURE Marion C. Kowalski DEGREE MD				22c. DATE SIGNED 12-17-84		22d. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MARION C. KOWALSKI				22f. ADDRESS 8604 HARFORD ROAD - PARKVILLE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 19, 1984		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CSM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS CHAPLOF MEMORIALS ADDRESS HARFORD RD. 8800				25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE Quinn R. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-prepare carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

Handwritten text, possibly a signature or name, located in the center of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 3 2 3 2 4								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Matilda E. SILK					2a. DATE OF DEATH MONTH DAY YEAR 12 7 84					2b. HOUR 5:45 AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 24 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.				
10. CITY OR TOWN OF DEATH Garrison Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrison Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store		
13a. STATE MD		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3438 Roland Ave. 21211		
14. FATHER'S NAME FIRST MIDDLE LAST Tilghman ISSAC				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Arnold						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-10-3262		17. INFORMANT ADDRESS Sharon Ammerhiser Patients Charts 16 Loomis Ct Owings Mills, Md						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Aorta M.I. DUE TO, OR AS A CONSEQUENCE OF (b). ASCVD DUE TO, OR AS A CONSEQUENCE OF (c). 2 hours										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d). S.P.R. @ Hx, L1 & L2, S.P. Endarterectomy.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-16-19 83 to 12-7-19 84, that (I) (we) lost saw the deceased alive on 12-7-19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Shankat Y. K. Han				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-7-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHANKAT Y. K. HAN				22e. ADDRESS 1528 KING WILLIAM DR; Balto, MD						
23a. BURIAL, CREMATION, REMOVAL (CHECK BY) Burial		23b. DATE Dec. 10, 1984		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto, Md.				
24. FUNERAL DIRECTOR Eckhardt Funeral Chapel				25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Podell				

10/10/10

NO 100 1002

10/10/10

10/10/10

10/10/10

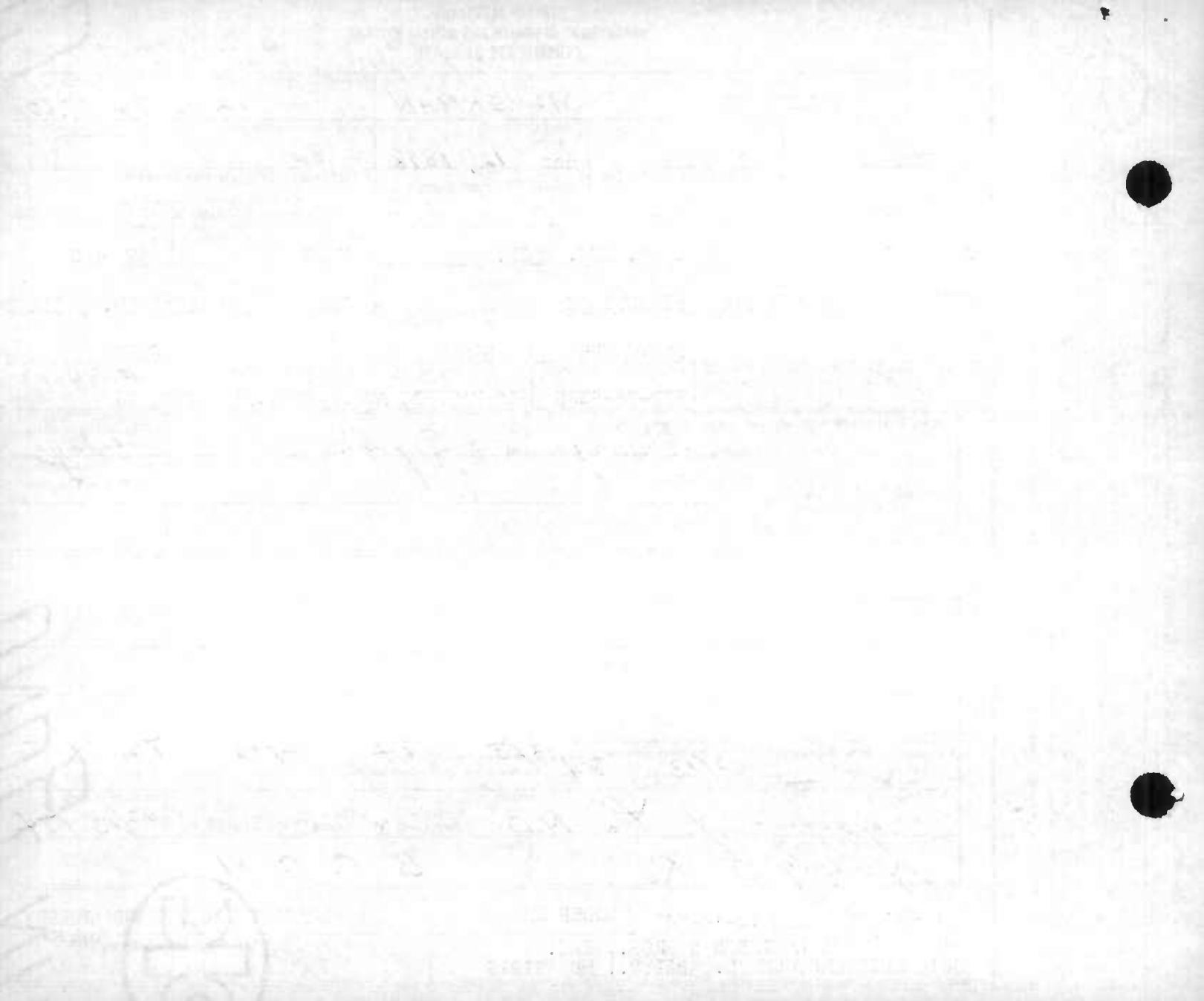
10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 2 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FANNY SILVERMAN			2a. DATE OF DEATH MONTH DAY YEAR 12 13 84			2b. HOUR 7:20 P	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR dec 12, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN PIKESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS KRETCHNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH GLICK		13e. STREET ADDRESS / ZIP CODE 7920 SCOTTS LEVEL RD. #21208			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-74-5345		17. INFORMANT ADDRESS ROTH MEMORIAL HOME #08401 116 PACIFIC AVE., ATLANTIC CITY, NJ			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia & Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>84</u> , to <u>12/13</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>12/13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Young S. Ro</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Young S. Ro</u>		22e. ADDRESS B. C. G. H.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL		23b. DATE 12-16-84		23c. NAME OF CEMETERY OR CREMATORY RODEF SHALOM		23d. LOCATION PLEASANTVILLE, NEW JERSEY	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 2016 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 19 1984			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in due time.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 2 6 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST						2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
		ENCARNACION B. SIMON						Dec. 2, 1984				M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		March 22, 1906				78 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.						Baltimore County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Timonium		14 Candlelight Ct.						Homemaker		Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Baltimore		Timonium				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 Candlelight Ct. 21093			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Damian Bartolome				Francisca Mata									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No		217-58-9606		Edilberto R. Beltran - Same as #13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
carcinomatosis										3 min			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) carcinoma - gallbladder										9 min			
(c) metastasis													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: cachexia due to carcinomatosis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)									
		6:40 P.M. Dec 2 1984											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
				St		84		Dec		84			
22a. I certify that (I) (this hospital) attended the deceased from above (I) (we) (did not) view the body after death.										19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Jose T. MORELOS				12/3/84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
Jose T. MORELOS		5601 Loch Raven Blvd		Baltimore Md 21234									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		12-6-84		Dulaney Valley		Timonium, Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Buck Towson Funeral Home, Inc.		1050 York Rd. Towson, Md. 21204		DEC 5 1984		Julia Davidson-Hendall							

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JOHN F. MOORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

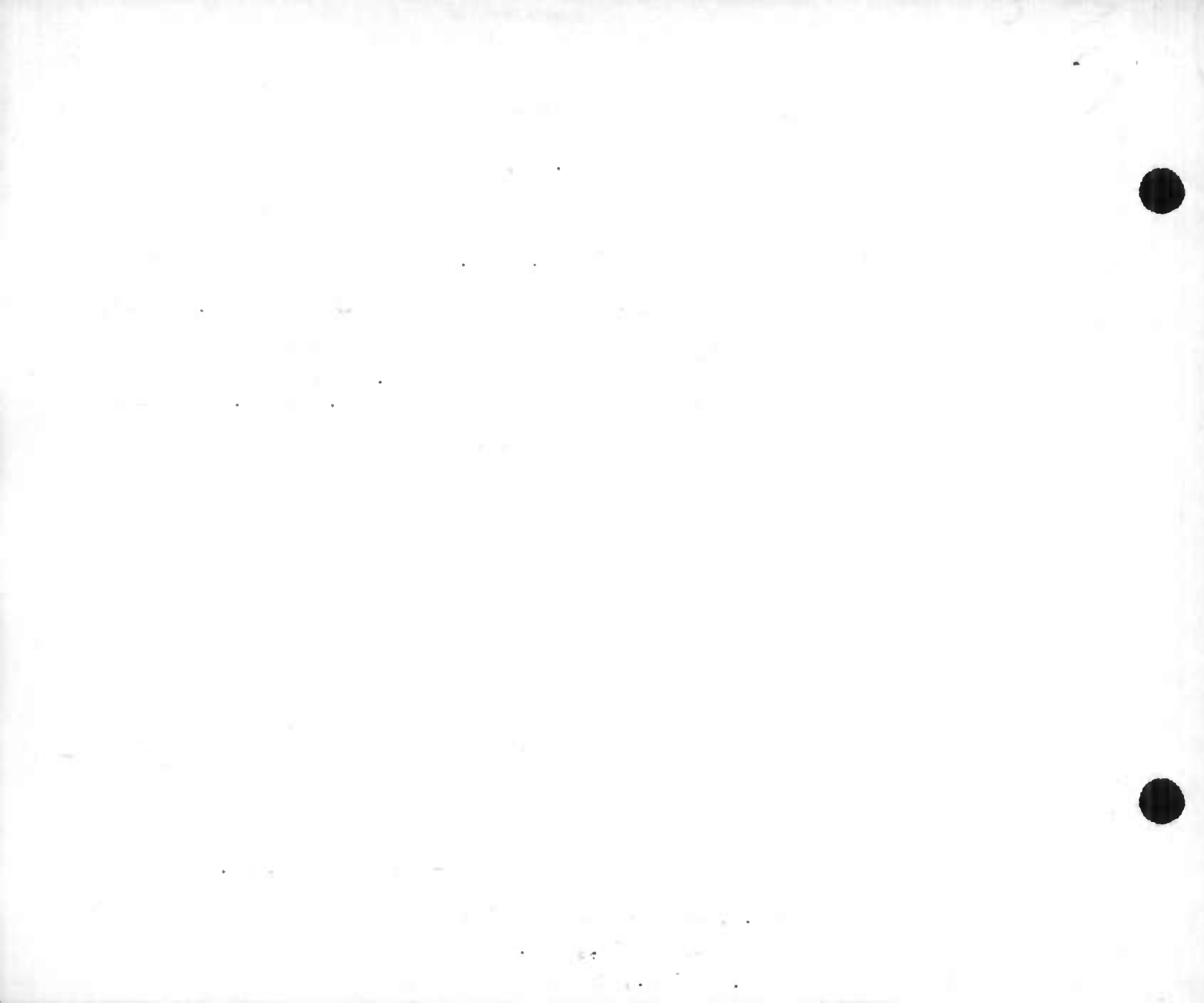
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be buried with the deceased within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 19, it shows only injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 3 2 7

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SANDRA SINGER		12/2/84		0107 M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 12, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. STREET ADDRESS / ZIP CODE 3813 BOWERS AVE. #21215		
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM ROTHMAN	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 216-01-8419D		17. INFORMANT MR. ALVIN SINGER 1035 FLAGTREE LA. BALTO., MD 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from Nov 18, 1984, to Dec 2, 1984, that (I) saw the deceased alive on Dec 1, 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Yakov Friedman		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec 2, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yakov Friedman		22e. ADDRESS BCGH - RANDALLSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC. 3, 1984	23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN	23d. LOCATION BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR DEC 7 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 3 2 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 12 12 1984			2b. HOUR M				
ADOLPH			J.			SKEBERDIS													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 12 12 19 84			2d. HOUR 1:28 a M			
Male		White		Jan. 20, 1927			57 YRS.												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				U.S.A.								Baltimore County MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville				230 Glenmore Ave.								Clerk				-Social Security Adm			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland				Baltimore				Catonsville				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				230 Glenmore Avenue 21228			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST								FIRST MIDDLE LAST											
Jacob Skeberdis								Katherine Tatoris											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
Yes				W V 2				216-20-0647				Annie Skeberdis				Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																			
(b) _____																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
22b. Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE				SIGNED							
Thomas D. Smith				Deputy Chief				12-12-84											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Thomas D. Smith, M.D.				111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				12/15/84				Holy Trinity Russian Orthodox -Elkridge				Md.							
24. FUNERAL DIRECTOR																			
Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228																			
25a. DATE REC'D. BY REGISTRAR																			
DEC 14 1984																			
25b. REGISTRAR'S SIGNATURE																			
John Davidson																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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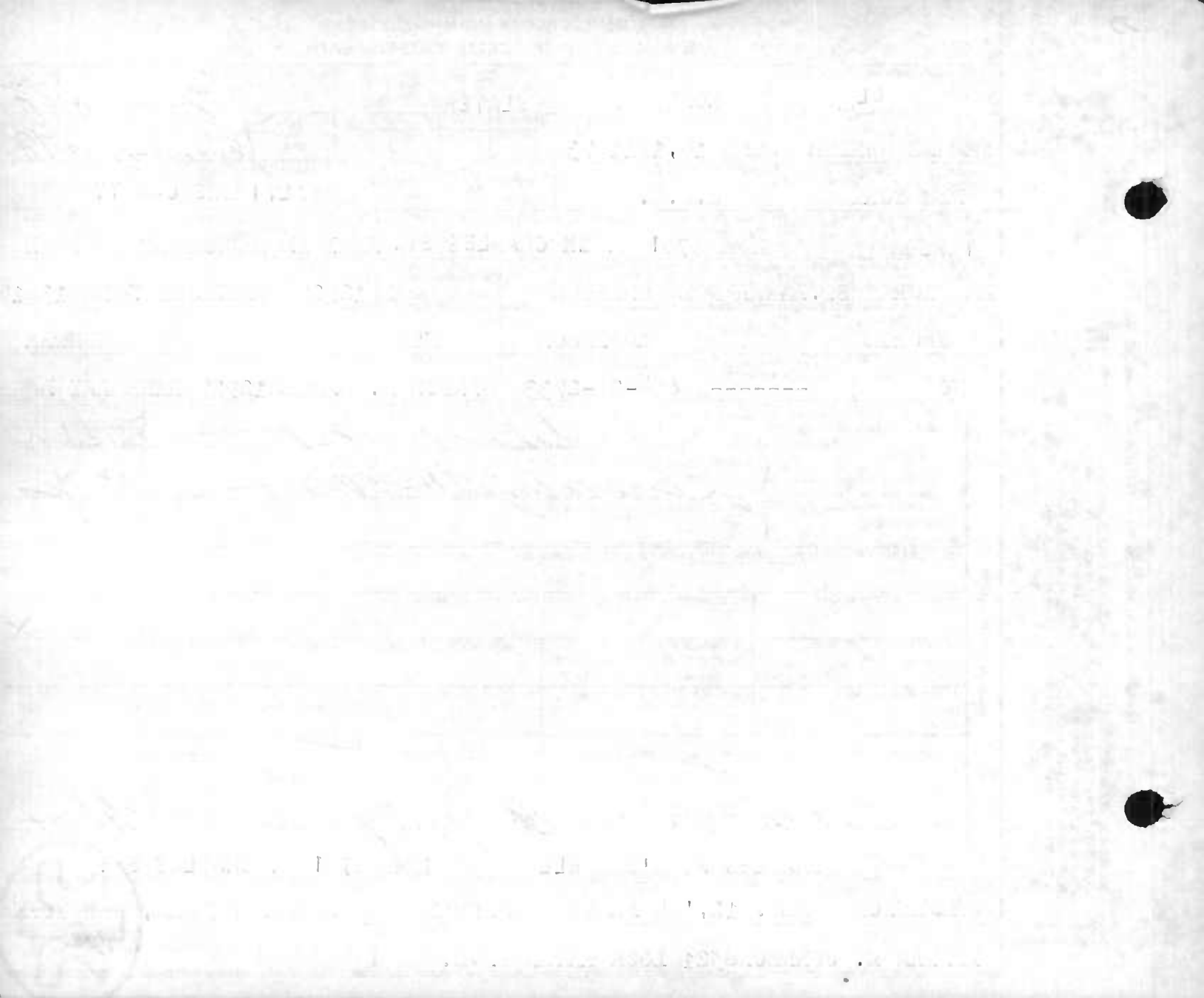


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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 3 2 9	
1. DECEASED NAME (TYPE OR PRINT) ELEANCER ROBINSON SLATER						2a. DATE KNOWN OF DEATH ESTIMATED December 9, 1984		2b. HOUR 8:30 AM			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1911	6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD December 9, 1984		2d. HOUR 9 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEDICAL SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL			
13a. STATE NEW YORK		13b. COUNTY ST. LAWRENCE		13c. CITY OR TOWN CLIFTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12927 CRANBERRY LANE 13617			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE ROBINSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH HUNTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 064-28-2733		17. INFORMANT ADDRESS GILSON M. SLATER 12927 CRANBERRY LANE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordone Arrest DUE TO, OR AS A CONSEQUENCE OF Generalized ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 2 ± 3 yr											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains and have, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Charles F. O'Donnell				TITLE SPECIFY M.D. Deputy				DATE SIGNED 12/11/84			
EXAMINER'S NAME (TYPE OR PRINT) CHARLES F. O'DONNELL				ADDRESS GBMC 6701 N. CHARLES ST.							
23a. BURIAL, CREMATION, REMOVAL TYPE CREMATION		23b. DATE DEC. 12, '84		23c. NAME OF CEMETERY OR CREMATORY PRAUB CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE CENTRAL SQUARE, NEW YORK					
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR DEC 10 1984		25b. REGISTRAR'S SIGNATURE John Davidson					



BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

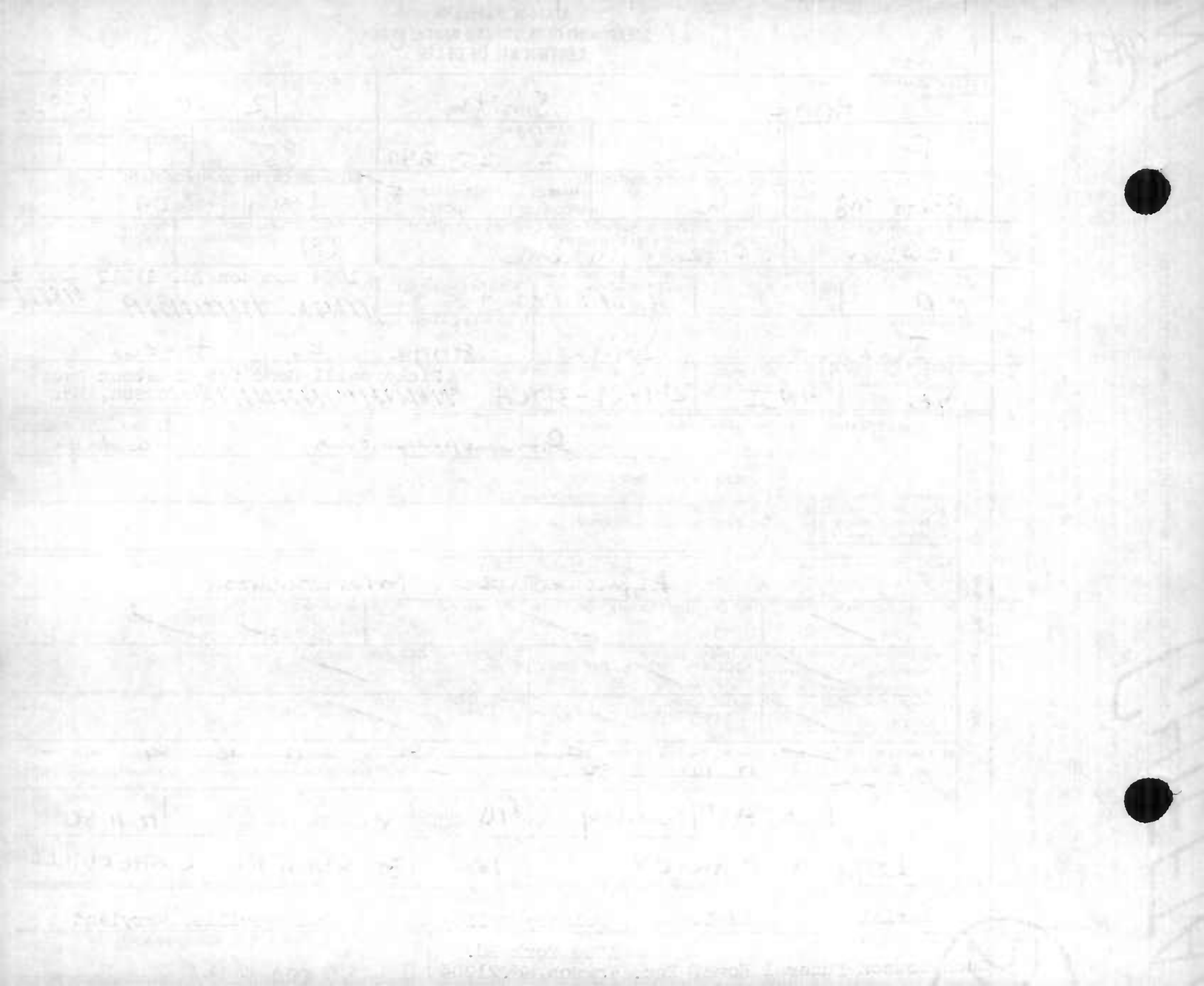
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a copy of the report will be furnished to the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 3 0 REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anne E. Smith						12 10 84		6 20 PM			
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2 25 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto Md		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County - Balto MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pickersgill, Inc				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RN		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.						13b. CITY OR TOWN BALT. CITY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1004 Woodson Rd. 21212	
14. FATHER'S NAME FIRST MIDDLE LAST Judson Smith						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne E. Askew					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II						16b. SOCIAL SECURITY NO. 214-22-3176A		17. INFORMANT Pickersgill Home 615 Chestnut Ave. Towson, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Kyphoscoliosis, Arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>June</u> , 19 <u>82</u> , to <u>12 10</u> , 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>12 10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Kerth A. Manley</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-11-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kerth A. Manley						22e. ADDRESS 1818 Pot Spring Rd LUTHERVILLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-14-84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204						ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John Davidson	

DEC 17 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post mortem examinations should be reported to the attending physician. The law requires that the death certificate be executed within 24 hours after death. Post mortem examinations should be reported to the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 3 3 1			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST MARGERY A. SMITH				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 25, 1984			
3. SEX FEMALE				2b. HOUR 1:15P M			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 20, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.	
10. CITY OR TOWN OF DEATH 21204		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1445 PUTTY HILL AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CREDIT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL SALES	
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		13d. STREET ADDRESS / ZIP CODE 1445 PUTTY HILL AVE. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST WARREN CARL WHITE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL NOBLE DICKEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 11 219-14-7434		17. INFORMANT ADDRESS LEONARD BAYARD SMITH, JR. BALTO., MD 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/21 19 84 to 12/25 19 87 that (I) (we) last saw the deceased alive on 12/16 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death)							
22b. SIGNATURE George T. Gilmore M.D.				DEGREE M.D.		22c. DATE SIGNED 12/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE T. GILMORE, M.D.				22e. ADDRESS 1717 YORK ROAD 252-3777			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE DEC. 28, '84		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GAR.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MD	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 3 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mrs. Pearl M. Smith						2a. DATE OF DEATH MONTH DAY YEAR December 3 1984				2b. HOUR 5 A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 11 1894		6. AGE (IN YEARS (LAST BIRTHDAY)) 90 YRS.		8. IF UNDER 1 YEAR MONTHS DAYS 0 0		9. IF UNDER 24 HRS. HOURS MIN. 0 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3227 Offutt Rd. 21133				
14. FATHER'S NAME FIRST MIDDLE LAST Oxford Kaufman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie (unknown) Kaufman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-0591D		17. DECEASED'S ADDRESS Mrs. Pearl Will 21784 704 Old Liberty Rd. Sykesville Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. M.I. Antero Lateral DUE TO, OR AS A CONSEQUENCE OF C.H.F Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-29 , 19 84 , to 12-3 , 19 84 , that (I) (we) last saw the deceased alive on 12-3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Ray Adorg						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAY ADORG GOVINDA RA						22e. ADDRESS Ball County Genl Hospital -							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-6-84		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133						25a. DATE REC'D. BY REGISTRAR DEC 7 1984		25b. REGISTRAR'S SIGNATURE John P. Ponder					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 3 3 3			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST RUTH R. SMITH						12/19/84						5:28 P.M.	
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 4-6-1902		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESLADY		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE					
13a. STATE MD.						13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7305 PARK DRIVE 21234	
14. FATHER'S NAME FIRST MIDDLE LAST LAFAYETTE SMITH						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMANDA McCARN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 165-16-3244		17. INFORMANT ADDRESS Mrs. Phebe E. Ingram - 7305 Park Drive 21234							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY/CARDIO ARREST/INSUFFICIENCY 3 HOURS DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA 3 HOURS DUE TO, OR AS A CONSEQUENCE OF (c) CHF AND RENAL FAILURE 2 WEEKS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I FOR RENAL (YEARS OF CHF)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 12/5 84 12/19 84							
22a. I certify that I (this hospital) attended the deceased from 12/19 84, 1984, to 12/19 84, 1984, that I (we) last saw the deceased alive on 12/19 84, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert Prince MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT PRINCE, MD				22e. ADDRESS GBMC									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-24-84		23c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HUGHESVILLE PA.					
24. FUNERAL DIRECTOR Davidson-Rendell						25a. DATE REC'D. BY REGISTRAR DEC 20 1984		25b. REGISTRAR'S SIGNATURE na Davidson-Rendell					

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FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 3 3 4

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Walter</u> <u>Smith</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12</u> <u>1</u> <u>84</u>		2b. HOUR <u>950A</u>						
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>12</u> <u>27</u> <u>1915</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>England</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.					
10. CITY OR TOWN OF DEATH <u>Randalltown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore County Gen</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Office Mgr.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>			
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Reisterstown</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>110 Corewood Ave 21136</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Jack</u> <u>F.</u> <u>Smith</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Anna</u> <u>M.</u> <u>Batten</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WWII</u>		17. INFORMANT <u>Mrs. Dorothy Smith - Same as #13</u>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Anterior-Lateral M.I.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diffuse vascular Atherosclerosis.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> , 19 <u>84</u> , to <u>12-1</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-1</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William J. Chircus M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>12-1-84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William J. Chircus M.D.</u>				22e. ADDRESS <u>32-K STOCK MALL RD 21208</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>12/1/84</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR (NAME) <u>Anatomy Board</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 06 1984</u>		25b. REGISTRAR'S SIGNATURE <u>J. L. Davidson</u>			
ADDRESS <u>Balto., Md.</u>											

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 3 3 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marjorie MAJORIE SMITH-WARD</i>				2a. DATE OF DEATH MONTH DAY YEAR 12 23 84			
2b. HOUR 2:30 PM							
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR 6-6-21		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Co. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE COUNTY MD</i>	
10 CITY OR TOWN OF DEATH <i>TOWSON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH FACILITY, GIVE STREET ADDRESS) <i>GBMC 6701 N. CHARLES ST.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Rtired</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Balto.</i> 13c. CITY OR TOWN <i>Balto.</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE <i>6102 Springwood Ct. -21206</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ebber Laster</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hisley</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-14-4116</i>		17 INFORMANT ADDRESS <i>Mr. Harvey A. Ward - 6102 Springwood Ct. 21206</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC CANCER OF LUNG</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-20</i> 19 <i>84</i> to <i>12-23</i> 19 <i>84</i> that (I) (we) last saw the deceased alive on <i>12-23</i> 19 <i>84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Jay M. Lustbader, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/23/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAY M. LUSTBADER MD</i>				22e. ADDRESS <i>GBMC 6701 N. CHARLES ST, TOWSON MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i>		23b. DATE <i>12-27-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulany Valley Mausoleum</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cockeysville Md.</i>	
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 26 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Sha Davidson-Randall</i>	

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IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG NO

1. DECEASED NAME (TYPE OR PRINT) CHARLES J. SOUTHCOMB			2a. DATE OF DEATH MONTH 12 DAY 25 YEAR 84			2b. HOUR 4:30 A M					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 11 DAY 05 YEAR 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS 00 DAYS 00		8. IF UNDER 24 HRS HOURS 00 MIN 00	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
13. CITY OR TOWN OF DEATH ROSSVILLE		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE ROSSVILLE NH				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DELIVERY			16. KIND OF BUSINESS OR INDUSTRY NEWSPAPER		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MARYLAND		17b. COUNTY BALTIMORE		17c. CITY OR TOWN BALTIMORE		18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. STREET ADDRESS 30 STABILIZER DR. 21220			
20. FATHER'S NAME FIRST WILLIAM MIDDLE SOUTHCOMB LAST SOUTHCOMB				21. MOTHER'S MAIDEN NAME FIRST MARTHA MIDDLE --- LAST ---							
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				23. SOCIAL SECURITY NO 220323656		24. INFORMANT ADDRESS OLGA SOUTHCOMB 30 STABILIZER DR.					
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ---											
26. DATE OF OPERATION			27. CONDITION FOR WHICH OPERATION WAS PERFORMED			28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 84			32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			35. LOCATION STREET CITY OR TOWN COUNTY STATE					
36. I certify that (I) (this hospital) attended the deceased from 12/24 19 84 to 12/25 19 84 , that (I) (we) last saw the deceased alive on 12/24 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
37. SIGNATURE Marion J. Rembrink MD			38. DEGREE MD			39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			40. DATE SIGNED 12/26/84		
41. PHYSICIAN'S NAME (TYPE OR PRINT) MARION J. REMBRINK MD			42. ADDRESS 805 FUSSELL AVE BALTO. MD 21220								
43. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			44. DATE 12/27/84		45. NAME OF CEMETERY OR CREMATORY WOODLAWN			46. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD			
47. FUNERAL DIRECTOR John Paul			48. ADDRESS 1211 Chesapeake Ave.			49. DATE REC'D. BY REGISTRAR DEC 26 1984			50. REGISTRAR'S SIGNATURE ---		



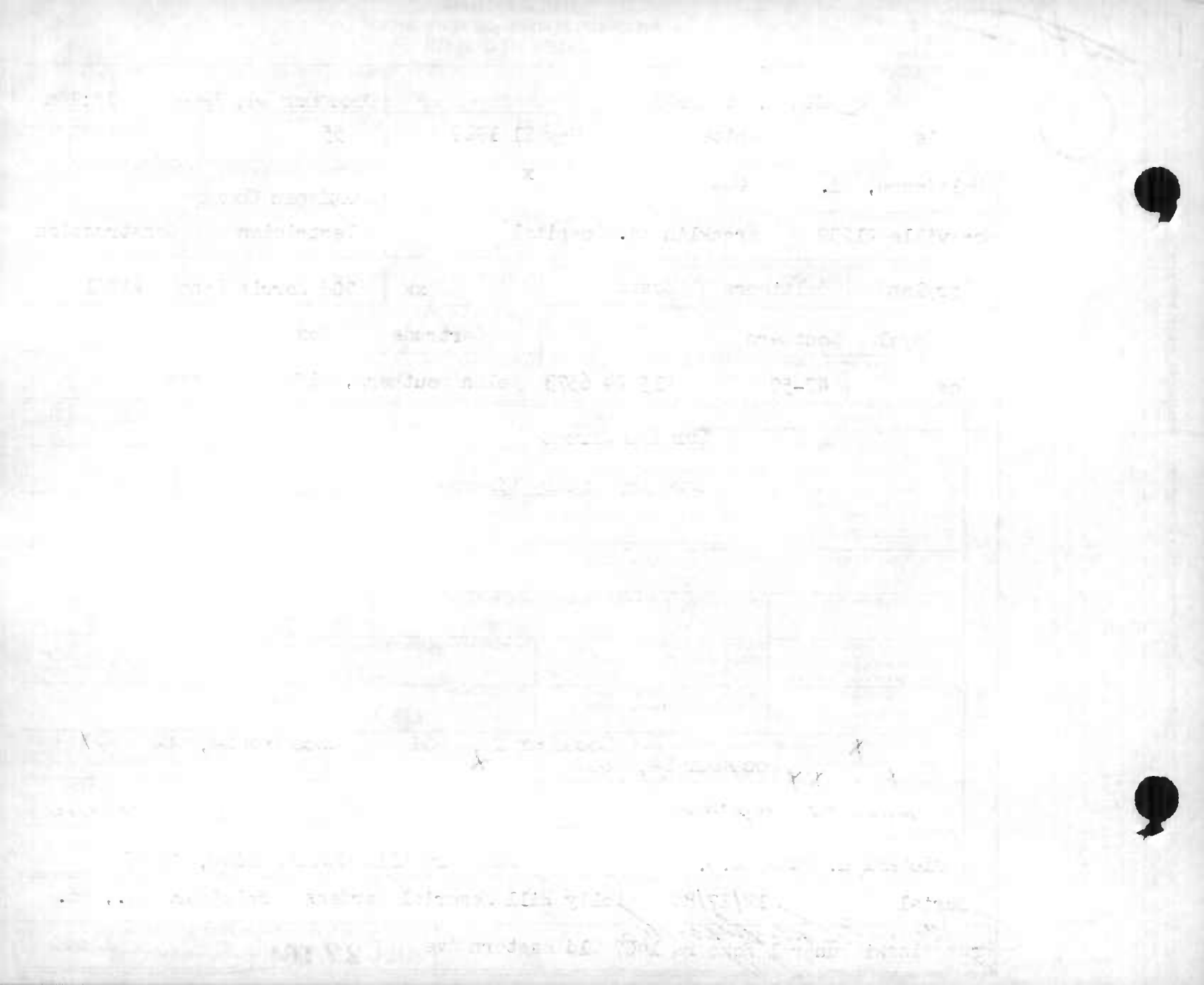
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 3 2 3 3 7								
1. DECEASED NAME (TYPE OR PRINT) Kenneth D. SOUTHERN					2a. DATE OF DEATH MONTH DAY YEAR December 24, 1984			2b. HOUR 11:14a M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 21 1929 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If place of death is nursing home, give street address) Franklin Sq. Hospital				12a. USUAL OCCUPATION (If deceased was not working, give occupation) Electrician		12b. KIND OF BUSINESS OR Construction		
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Royal Southern					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Fox					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Helen Southern, Wife Same						
16a. Yes		47-50		215 24 6573						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 24, 1984, to December 24, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 24, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.										
22b. SIGNATURE Michael A. Stang M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/24/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Stang M.D.				22e. ADDRESS 9000 Franklin Square Drive, 21237						
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d. LOCATION Baltimore Co., Md.				
24. FUNERAL HOME OR Brazdzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 3 3 8

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGARST E. SPARKS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 13, 1984		2b. HOUR 6:35 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 28, 1917	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dubansky Towson N. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN PARKVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3344 WILLOUGHBY ROAD 21234
14. FATHER'S NAME FIRST MIDDLE LAST AUGUST MATTHEISS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARST THIELS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215 10 8409		17. INFORMANT FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Pulmonary Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Steele Richardson Syndrome					+ - 4 years
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized ASCVD					+ - 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 30, 1983 to Dec 13, 1984 , that (I) (we) last saw the deceased alive on Dec 12, 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not see the body after death, so state.)					
22b. SIGNATURE OF PHYSICIAN Dr. Charles F. O'Donnell					22c. DATE SIGNED 12/13/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. CHARLES F. O'DONNELL			22e. ADDRESS 7501 York Road - Towson 21204		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 15, 1984	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME EVANS CHAPL OF MEMORIES HARFORD		ADDRESS 8800 RD.		25a. DATE REC'D. BY REGISTRAR DEC 14 1984	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

MEDICAL CERTIFICATION

[Faint, illegible handwriting covering the upper and middle portions of the page.]

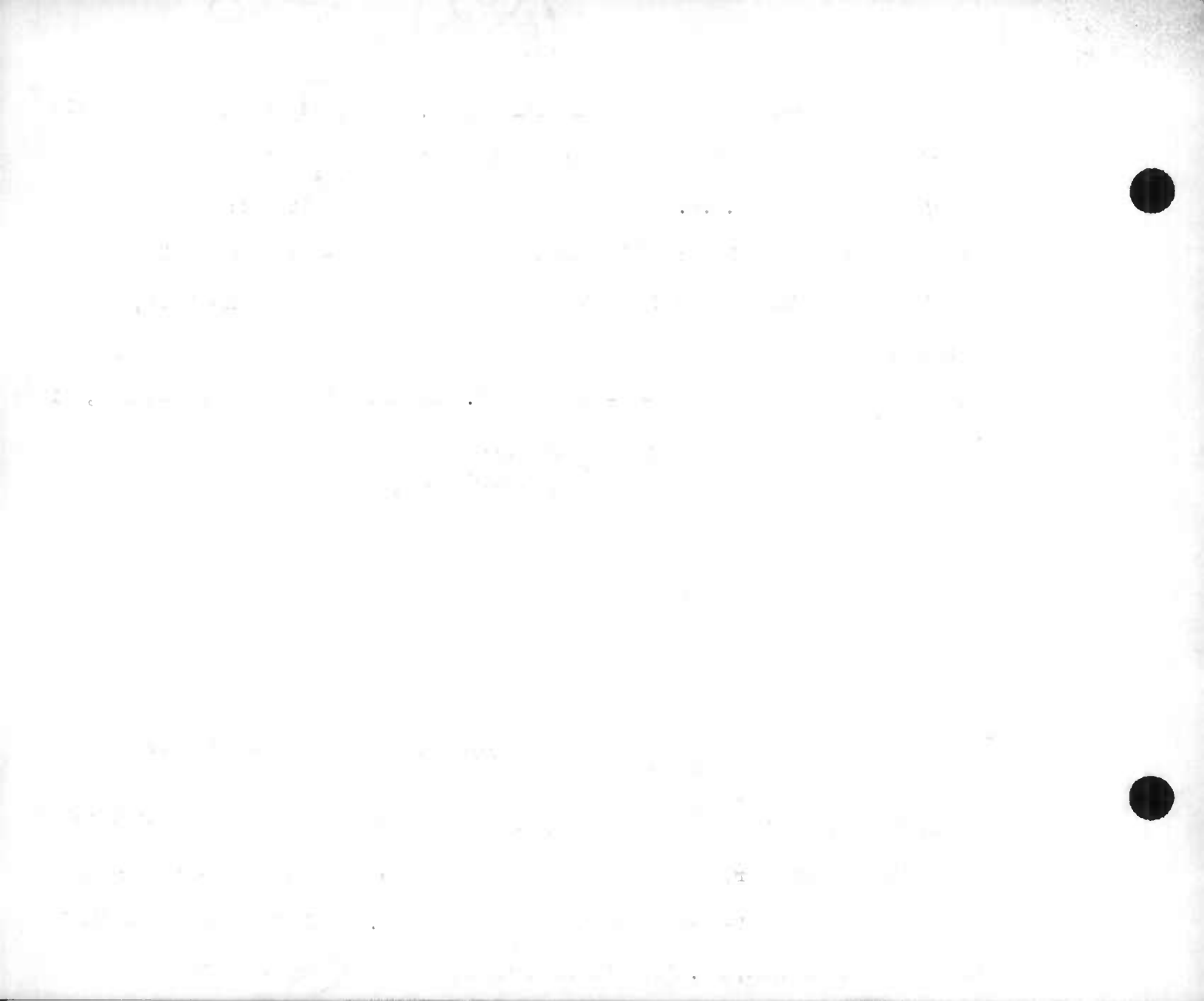
[Faint handwriting at the bottom of the page, including a signature and a date.]
Dec 12 1882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREW SPRAINIS SR.					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 4, 1984			2b. HOUR P 4:30 M		
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 13 93		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		8. UNDER 1 YEAR MONTHS 9. UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2203 Rockwell Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY TAVERN		
13a. STATE MARYLAND					13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2203 ROCKWELL AVENUE, 21228	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE SPRAINIS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-30-3158		17. INFORMANT ADDRESS IDA I. SPRAINIS 2203 ROCKWELL AVENUE, 21228						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE & LONG CVA DUE TO, OR AS A CONSEQUENCE OF CASEVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF: APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (i) (this hospital) attended the deceased from 4/15/1976 to 12/4/1984 that (i) (we) last saw the deceased alive on 12/4/1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Anil Fatterpaker DEGREE MD				22c. DATE SIGNED 12/5/84				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anil Fatterpaker, MD		
22e. ADDRESS 4713 Leeds Avenue, Baltimore, Maryland				22f. DATE REC'D. BY REGISTRAR DEC 6 1984						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-07-84		23c. NAME OF CEMETERY OR CREMATORY IMMANUEL LUTHERAN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND				
24. FUNERAL DIRECTOR: NAME HUBBARD FUNERAL HOME, INC.				24b. ADDRESS 4107 Wilkens Avenue		25. REGISTRAR'S SIGNATURE John Davidson				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 4 0 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) ELEANOR SUE SPUNT						2a. DATE OF DEATH MONTH DAY YEAR 12 26 84				2b. HOUR 6 13 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 5 36		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER			
13a. STATE MARYLAND						13b. COUNTY BALTIMORE		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST ISIDORE RAY BACH						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARION ALTMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 490-31-0456		17. INFORMANT ADDRESS EMANUEL SPUNT 3907 BRYONY RD. (21133)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/21/84 to 12/26/84, that (I) (we) last saw the deceased alive on 12-26-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE D. DEPESTRE MD				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/26/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. DEPESTRE				22e. ADDRESS BALTIMORE COUNTY GENERAL HOSP.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN, BALTIMORE, MD.							
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 601 REISTERSTOWN RD. BALTIMORE, MD. (21215)				25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall							

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 3 4 1	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY DELWARE STATHAM						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> 12 25 1984		2b. HOUR 0100 AM			
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 9 16 1912	6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 25 1984		2d. HOUR 1145			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD.					
10. CITY OR TOWN OF DEATH Turners Station		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 708 Peach Orchard				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm			
13a. STATE Va.						13b. CITY OR TOWN Appomattox		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Statham						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Sue Morgan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 227-227003		17. INFORMANT ADDRESS Tas Statham 2802 Sparrows Pt. Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Chronic hypertensive cardiovascular disease (b) Chronic hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE J. Crossan O'Donovan				TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 12/25/84			
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN				ADDRESS 242 Dundalk Ave., Balt., Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-84		23c. NAME OF CEMETERY OR CREMATORY Statham Family Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Appomattox, Va.				
24. FUNERAL DIRECTOR NAME Jas A. Morton & Sons						ADDRESS 1701 Laurens St.		25a. DATE REC'D BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

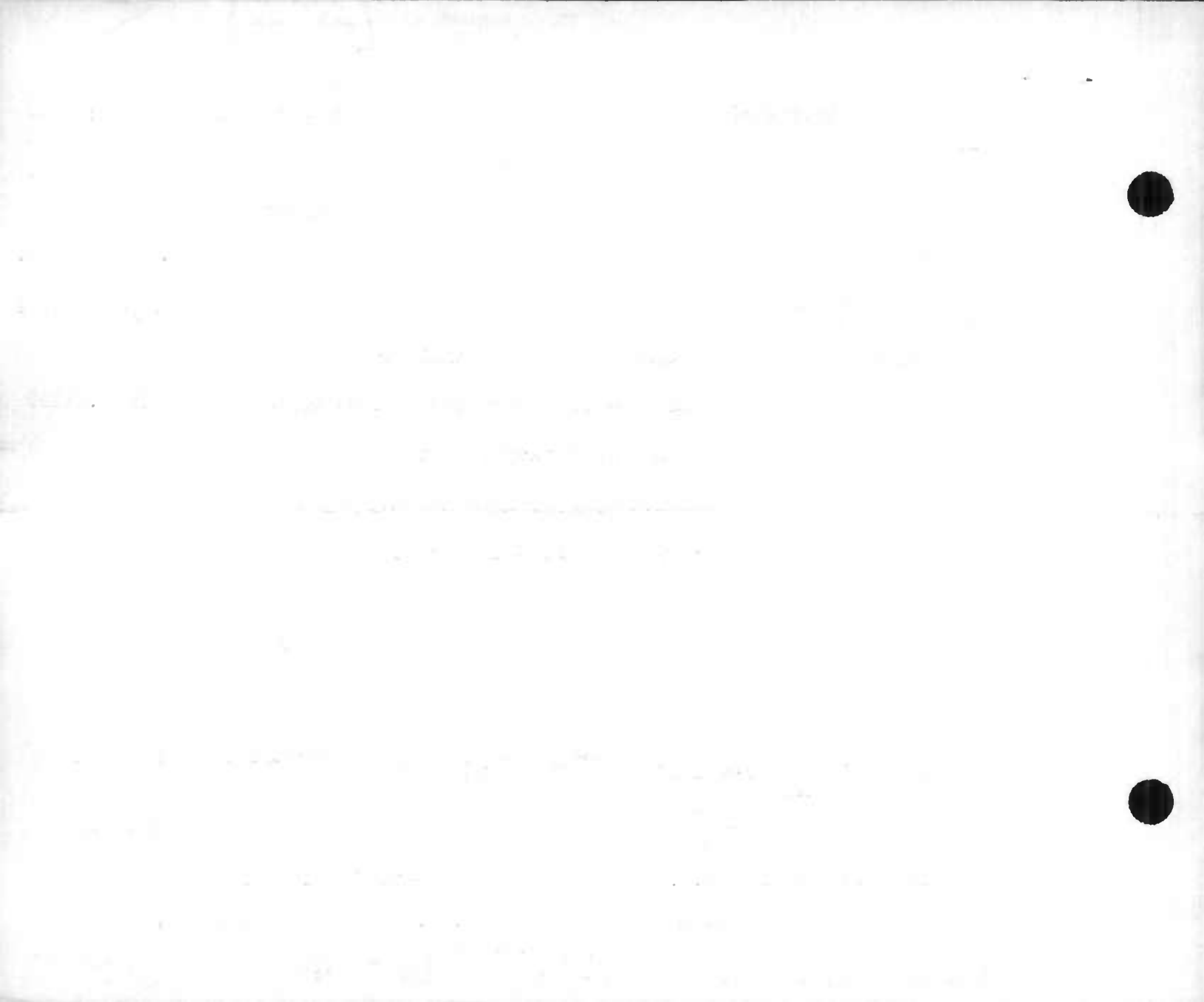
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		3 2 3 4 2		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) Frank STEFAN				2a DATE OF DEATH MONTH DAY YEAR December 24, 1984		2b HOUR 9:55 p.m.			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 11 11 13		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b KIND OF BUSINESS OR INDUSTRY R. Vincent Co.	
13a STATE MARYLAND		13b CITY OR TOWN BALTIMORE		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS / ZIP CODE 10412 Vincent Farm Lane 21220			
14 FATHER'S NAME FIRST MIDDLE LAST Andrew Stefan				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 220-05-4119		17 INFORMANT ADDRESS Margaret Parlett 10510 Bird River Rd. 21220					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive Re-Infarction of Myocardium DUE TO, OR AS A CONSEQUENCE OF (c) Previous Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 13, 1984, to December 24, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 24, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death.									
22a SIGNATURE Julio Schwartzman				DEGREE M.D.		22b DATE SIGNED 12-24-84			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Julio Schwartzman				22e ADDRESS 9000 Franklin Square Dr., 21237					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12-28-84		23c NAME OF CEMETERY OR CREMATORY Holly Hills M. G.		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24 FUNERAL DIRECTOR NAME Lassahn Funeral Home				ADDRESS 7401 Belair Rd. BALTO. MD. 21206		25a DATE REC'D. BY REGISTRAR DEC 31 1984		25b REGISTRAR'S SIGNATURE Julia Davidson	

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 3 4 3

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edward J Stefanski</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 23 84</i>			2b. HOUR <i>905 AM</i>				
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 1 32</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co.</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Stella Maria Hospice</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CARPENTER</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF HOSPITAL HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>325 Robbins Way 21151</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>EDWARD J STEFANSKI</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Kathleen Byers</i>				16. ADDRESS <i>PL</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>UNUS</i>			16b. SOCIAL SECURITY NO. <i>211-28-0494</i>		17. INFORMANT <i>ANNA BYERS 5129 FARNSWORTH</i>				18. ADDRESS <i>PL</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Transitional Cell Ca - Bladder</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12 23 84</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/23</i> , 19 <i>84</i> , to <i>12/23</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12/21</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Dr. Fauller MD</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>12/27/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MEADOW RIDGE</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. MD.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>J.E. CONNELLY 300 MACE</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Galia Davidson-Randall</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner should be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 places any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHWH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 3 4 4

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George V. STEFFEY			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1984			2b. HOUR 9:25 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 16, 1919 ^{AR}		6. AGE (IN YEARS LAST BIRTHDAY) 65		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Square Hospital				12a. USUAL OCCUPATION Retired Machinist		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2502 Linwood Rd 21234			
14. FATHER'S NAME William L Steffey				15. MOTHER'S MAIDEN NAME Fannie Mary Ball					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11 215-07-6441		17. INFORMANT ADDRESS Mrs Doris S Steffey Same As 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Lung carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Massive pleural effusion PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from Nov. 27, 1984, to Dec. 17, 1984, that (we) last saw the deceased alive on Dec 17, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE Ralph Cardamone, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Cardamone, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/21/84		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25. DATE REC'D BY REGISTRAR DEC 19 1984		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

1977

100-100000

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[Faint, mostly illegible text and markings covering the majority of the page, possibly representing a document or form.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 4 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucy D. Steger			2a. DATE OF DEATH MONTH 12 DAY 24 YEAR 84			2b. HOUR M											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 9 YEAR 95		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7b. IF UNDER 24 HRS HOURS 0 MIN. 0							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD											
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home Maker								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 4005 Third Street 21225													
14. FATHER'S NAME FIRST Thomas MIDDLE Drowskiewicz LAST Drowskiewicz				15. MOTHER'S MAIDEN NAME FIRST Stella MIDDLE Ordakowski LAST Ordakowski													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-42-0562		17. INFORMANT Martha E. Jones 1900 Rollingwood Road				18. DATE OF DEATH 12/28/84									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (b) years DUE TO, OR AS A CONSEQUENCE OF (c) years										19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (1) (this hospital) attended the deceased from May 1984 to Dec 1984 , that (2) (we) lost saw the deceased alive on 12/23 19 84 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE J. C. Pound				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. C. Pound				22e. ADDRESS 2108 Edmonstone Ave, Balto. Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		23d. LOCATION CITY OR TOWN Balto COUNTY A.A. STATE Md											
24. FUNERAL DIRECTOR George J. Gonce				4001 Ritchie Hgwy Balto Md				25a. DATE REC'D. BY REGISTRAR DEC 26 1984		25b. REGISTRAR'S SIGNATURE John Davidson Randell							

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12 24 1 AM

Baltimore County

St. Joseph's Nursing Home

Catonville

4005 Third Street, S1222

Baltimore

MD

1222 Trowell Dr.

Talia

Brownlievic

James

St. Joseph's Nursing Home, Catonville, MD.

S12-12-0002

S1222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 3 4 6

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frieda Klein Steil			2a. DATE OF DEATH MONTH DAY YEAR Dec. 6, 1984			2b. HOUR MIN. 4:25 A				
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 11- 22- 96		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 88		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson Baltimore County				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Glen Arm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13020 Dulaney Valley Rd. 21057	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Charles Klein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Drompp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220/46/3678		17. INFORMANT ADDRESS Mary Louise Carroll same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } Recent cerebral thrombosis Advanced arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Right iliac artery occlusion										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR May 24 1982			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2300 Dulaney Valley Rd. Towson, Md. 21204				
22a. I certify that (I) (this hospital) attended the deceased from May 24 1982 to Dec. 6 1984 , that (I) (we) lost saw the deceased alive on Nov. 26 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. All (we) (I) (did not) view the body after death.										
22b. SIGNATURE Dr. E. Nakhuda			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 6, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 2300 Dulaney Valley Rd. Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/7/1984		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc. Balto., Md. 21222						25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE John R. [Signature]		

MEDICAL CERTIFICATION

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REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
ON THE
LANDS BELONGING TO THE STATE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 11, 1911

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS
1911



ALBANY: J.B. LIPPINCOTT & CO., PRINTERS
1911

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS
1911

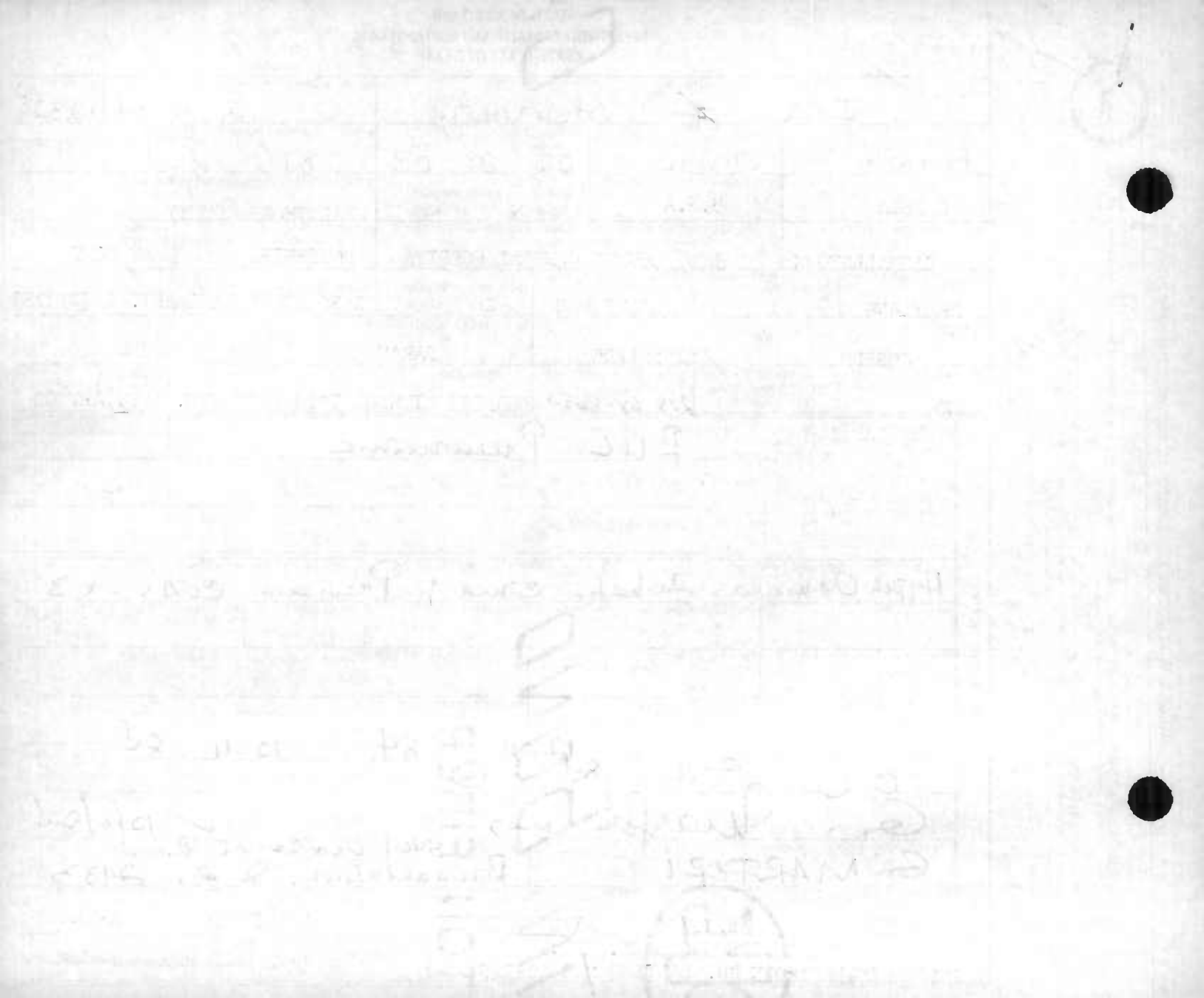
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 4 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida FE Steinberg			2a. DATE OF DEATH MONTH DAY YEAR 12 11 84			2b. HOUR 12 32 P	
3 SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06 28 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
11. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME		13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 3636 FORDS LANE APT. E (21215)	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH EISENBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH TUROW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-64-8680		17. INFORMANT ADDRESS (21215) BERNICE MITNICK 7010 PARK HTS. AVE., APT G2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUL Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hyper Osmolar Diabetic coma; Previous CVAs - x 3</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-11</u> 19 <u>84</u> , to <u>12-11</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-11</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) see the body after death.							
22b. SIGNATURE <u>G. Martori</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. MARTORI				22e. ADDRESS Randallstown, Ind. 21133			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/13/84		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM CEM		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE ne Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner would not be notified or enter.

BP

DHMH-16 20M
(VRA 15, 4) 7/78

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 3 4 8	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. TIME OF DEATH	
FIRST Mose MIDDLE Eli LAST Stewart Mose Eli STEWART		MONTH DAY YEAR 12 - 19 - 84		5:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
MALE	Black	MONTH DAY YEAR 1896	88 YRS	Catonsville Md. County	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland USA	U.S.A.		Catonsville Md. County		
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	15. KIND OF BUSINESS OR INDUSTRY		
Catonsville	Spring Grove Hospital Center	Railroad	Unknown		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. INSIDE CITY LIMITS?	18. STREET ADDRESS		19. ZIP CODE
13a. STATE 13b. COUNTY Maryland Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Wade Ave		21228
20. FATHER'S NAME		21. MOTHER'S MAIDEN NAME		22. INFORMANT	
FIRST MIDDLE LAST Benjamin Stewart		FIRST MIDDLE LAST Mollie Mary Johnson		ADDRESS	
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		24. SOCIAL SECURITY NO.		25. WHERE DECEASED	
Unknown		219-54-383		Spring Grove State Hosp. Records	
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
28. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic brain hypoxia</u>					
29. DATE OF OPERATION		30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33. TIME OF INJURY		34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
35. INJURY OCCURRED		36. PLACE OF INJURY		37. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
38. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
39. SIGNATURE		40. DEGREE		41. DATE SIGNED	
<u>[Signature]</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/19/84	
42. PHYSICIAN'S NAME (TYPE OR PRINT)		43. ADDRESS		44. LOCATION	
MICHAEL A. HEREDIA		SPRING GROVE HOSPITAL CENTER		CITY OR TOWN COUNTY STATE	
45. BURIAL, CREMATION, REMOVAL (SPECIFY)		46. DATE		47. NAME OF CEMETERY OR CREMATORY	
Cremation		12-26-84		Security Process	
48. FUNERAL DIRECTOR		49. DATE REC'D. BY REGISTRAR		50. REGISTRAR'S SIGNATURE	
NAME ADDRESS MacNabb Funeral Home Catonsville Md		DEC 27 1984		<u>[Signature]</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

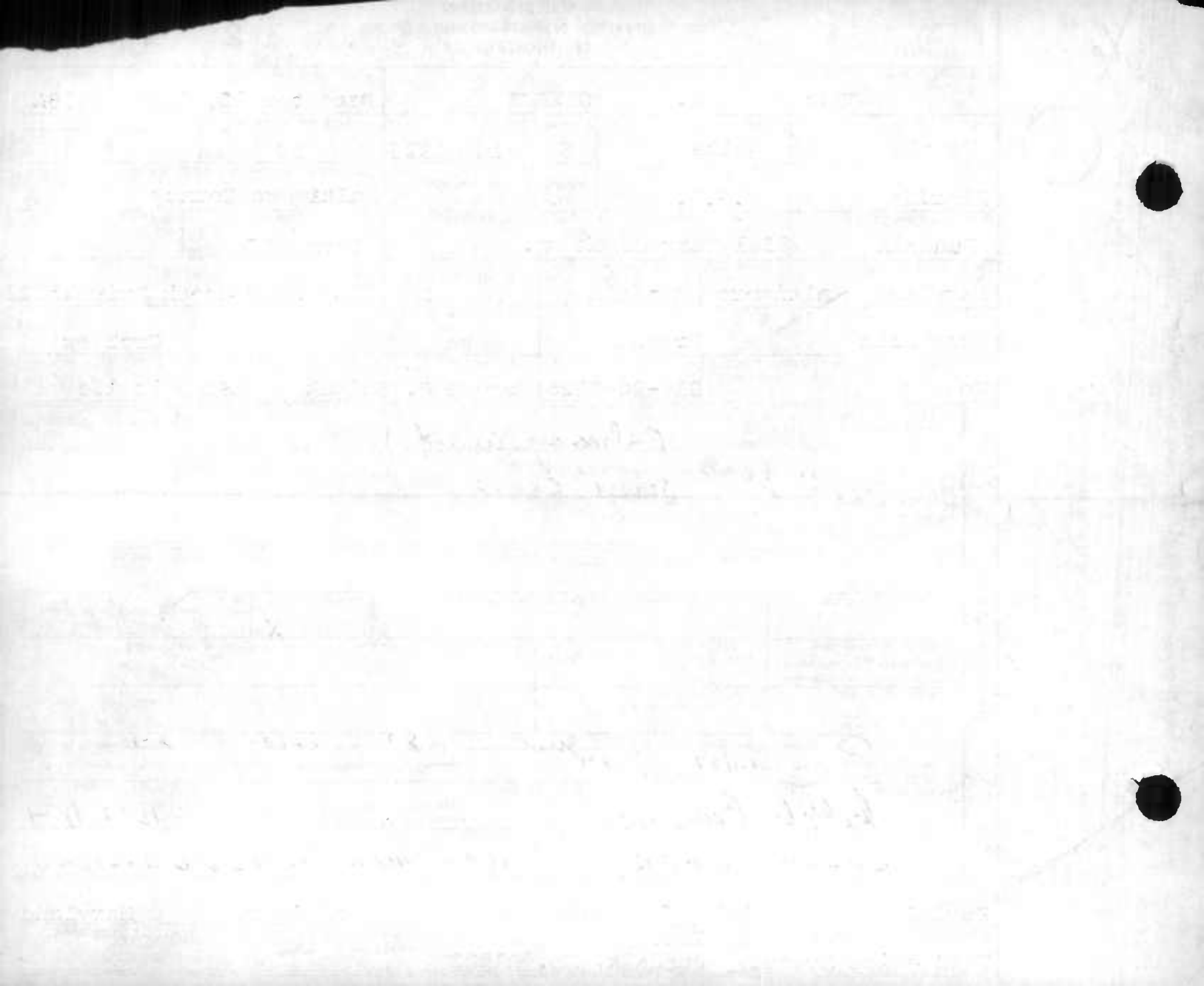
32349

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JUNE F. STIPEK		2a. DATE OF DEATH MONTH DAY YEAR December 30, 1984		2b. HOUR 5:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 10 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8341 Bear Creek Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8341 Bear Creek Drive 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Grnville Bryant				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Crocker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-20-3326		17. INFORMANT Jerome J. Stipek		ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>SEVERE CORD</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>87</u> , to <u>12/30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Ralph Baier</u>		DEGREE		22c. DATE SIGNED 12/30/87				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH BAIER		22e. ADDRESS 1390 MARTIN BLVD BALTIMORE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/2/1985		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 2 1985	
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 3 5 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Paul H. Stogoski				2a. DATE OF DEATH MONTH DAY YEAR 12 12 84				2b. HOUR M M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 25 28		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production Clerk		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 8115 Edwill Ave. 21237			
14. FATHER'S NAME FIRST MIDDLE LAST Paul J. Stogoski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Pietszkie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 11				16b. SOCIAL SECURITY NO. 218-26-1064		17. INFORMANT ADDRESS (21237) Geraldine F. Stogoski 8115 Edwill Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <i>64</i> to 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>10/4</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did) (not) view the body after death.											
22b. SIGNATURE <i>John D. Orth</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>12/12/84</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Orth, M. D.						22e. ADDRESS 7620 York Rd. Towson, Md. 21204 (337-1766)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-15-84		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				ADDRESS 7401 Belair Rd. BALTO MD. 21234		25a. DATE REC'D BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

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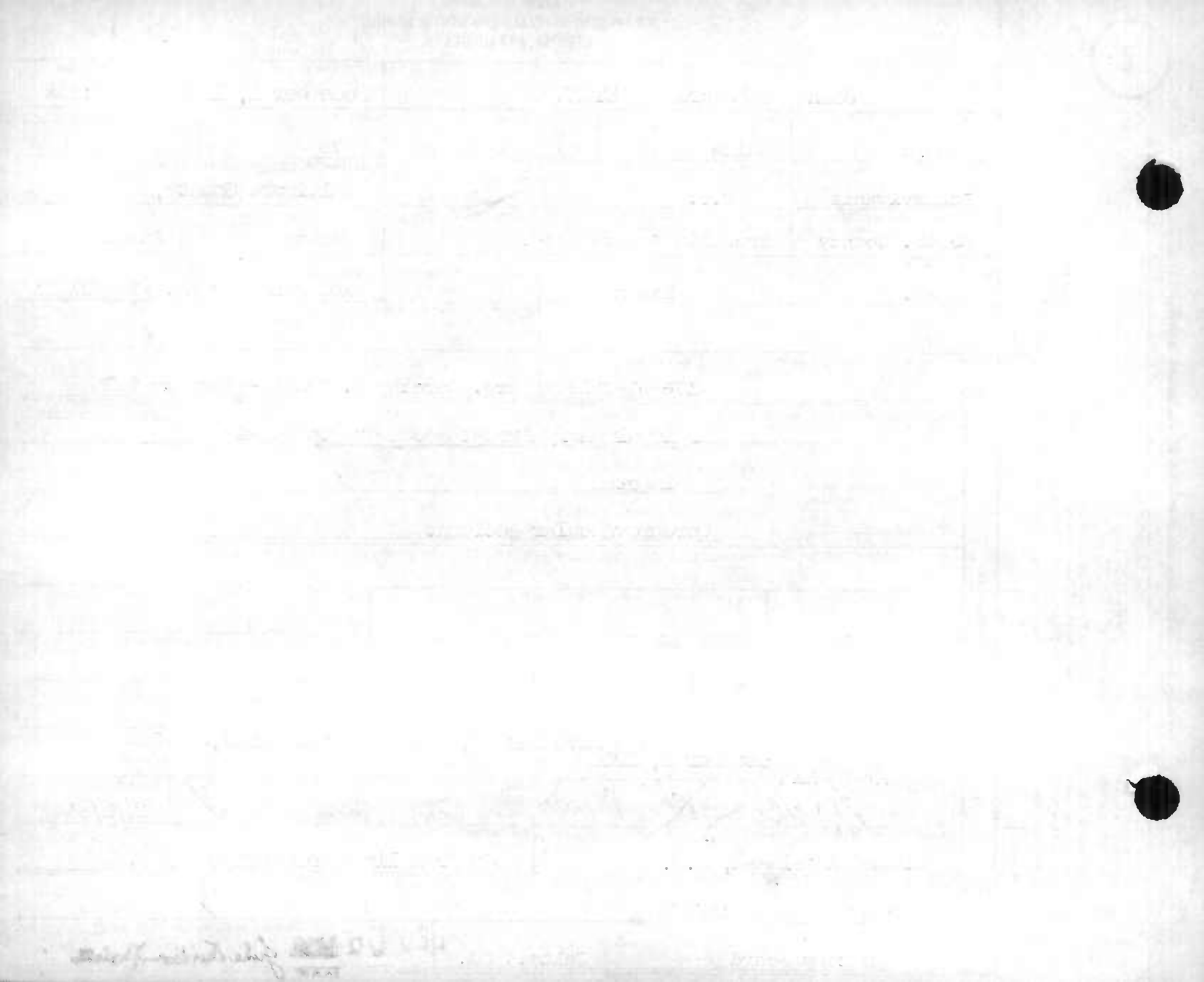
B

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
John Edward STULL					December 1, 1984	8:40A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	5 14 08		76 YRS.	Baltimore County, MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	U.S.			Baltimore County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto. County	Franklin Square Hosp.		Worker		Steel	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
Md.	BALTO	Essex			102 Kingsley Rd. #1 21221	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		176-07-9913		Mrs. Dorothy M. Stull - Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest Secondary to Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Accident</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 25, 1984</u> , to <u>December 1, 1984</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 1, 1984</u> , and that in <input checked="" type="checkbox"/> (a) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (b) view the body after death.						
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
				12/1/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
Gordon Handelsman, M.D.		9000 Franklin Square Drive		21237		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		12/1/84				
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Anatomy Board		460 460				
		Balto., Md.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Melvin W. Stull</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12 22 1984</u>		2b. HOUR <u>10:47 PM</u>	
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>12 25 1900</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balt. County</u> MD.
10. CITY OR TOWN OF DEATH <u>Rapallstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Balt. County Gen. Hosp</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Baker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Balt.</u>		13c. CITY OR TOWN <u>Catonsville</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Howard W. Stull</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ella M. Wachter</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>220-10-5744</u>		17. INFORMANT ADDRESS <u>9833 Gordon Court</u> <u>Walkersville, MD. 21793</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>L.H.L. Pneumonia</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <u>12 22 1984</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN IIFM IB PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> , 19 <u>84</u> , to <u>12-22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>William J. Clinch</u> M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12-22-84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William J. Clinch</u>				22e. ADDRESS <u>32-K Stockmill Rd 21208</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/26/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FaithUCC Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Charlesville, Frederick, MD.</u>
24. FUNERAL DIRECTOR NAME <u>G. Douglas Stauffer</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 28 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Burdson-Randall</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or shown to show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 2 3 5 3				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Theresa M. Tabor</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 6 1984</i>			2b. HOUR <i>PM</i> MIN. <i>9:40</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 15, 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St Joseph Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Baltimore</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1700 Meridene Dr., Apt. 215-21239</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Wenzel Schramm</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					
16b. SOCIAL SECURITY NO. <i>216-12-0820</i>		17. INFORMANT ADDRESS <i>Dolores Yewell -1014 Adcock Rd. 21093</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Nephrosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Diabetes mellitus, Hypertensive Arteriosclerotic C.V. Dis.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11/26 19 84</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>7620 York Rd. Towson MD 21204</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/26 19 84</i> to <i>12/6 19 84</i> , that (we) last saw the deceased alive on <i>12/6 19 84</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Lester A. Wall Jr.</i> M.D.					DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>12/6/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LESTER A. WALL, JR., M.D.</i>					22e. ADDRESS <i>7620 York Rd. Towson MD 21204</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-10-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Parkville, Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</i>		ADDRESS <i>1050 York Rd.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 10 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Shelia Davidson-Randall</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 5 4
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Richard TARBURTON			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1984		2b. HOUR 11:33pM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 29 1924	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 74 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist	12b. KIND OF BUSINESS OR INDUSTRY Auto Mfg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Emerson TARBURTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances NAGENGAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII	17. INFORMANT ADDRESS 2143 Redthorn Rd. Jean Scible, Daughter Balto., Md. 21220		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Multiple Myeloma**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Thrombocytopenia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ☒ (this hospital) attended the deceased from **November 27, 1984**, to **December 10, 1984**, that ☒ (we) last
saw the deceased alive on **December 10, 1984**, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) did ~~XXXX~~ view the body after death.

22b. SIGNATURE <i>Michael A. Taylor, M.D.</i>	DEGREE	22c. DATE SIGNED 12/16/84
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Taylor, M.D.	22e. ADDRESS 9600 Franklin Sq Drive 21237	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>

23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial	23b. DATE 12/13/84	23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.
24. FUNERAL HOME Brazdzinski Funeral Home PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR DEC 13 1984	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 5 5
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Daisy Geneyieve Taylor			2a. DATE OF DEATH MONTH DAY YEAR December 25, 1984		2b. HOUR 6:15 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 25 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank C. Ripley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah E. Joyce			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-20-6486		17. INFORMANT ADDRESS 21093 Dr. James E. Taylor, 7 Fox Knoll Ct.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stroke, ischemic, midbrain DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c) 15 yrs +		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-22 , 19 84 , to 12-25 , 19 84 , that (I) (we) last saw the deceased alive on 12-25 , 19 84 , and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Wm Carl Ebeling		22c. DATE SIGNED 12-26-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C Ebeling, M.D.		22e. ADDRESS 7620 York road towson Md 21204	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/29/84	23c. NAME OF CEMETERY OR CREMATORY Hampstead Meth. Ch. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Carroll, Md
24. FUNERAL DIRECTOR NAME ADDRESS Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd.		25a. DATE REC'D. BY REGISTRAR DEC 28 1984	25b. REGISTRAR'S SIGNATURE Jana Darden



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed and filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 5 6 REG. NO.	
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR		
					GEORGE F. TAYLOR		12 14 '84		3:45A _M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		APRIL 11, 1907		77		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
DELAWARE		UNITED STATES				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		GBMC-6701 N. CHARLES ST.				RETIRED		NESTLÉ Co.			
13a. STATE		13b. CITY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE					
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3406 WESTFIELD AVE.		21230			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
ARTHUR		HELEN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		212-09-757A		ELIZABETH H. TAYLOR (SAME AS 13)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) DISSEMINATED INTRAVASCULAR COAGULATION										1 WEEK	
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS										1 WEEK	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
MULTIPLE MYELOMA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		STREET							
22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1984, to 12/14, 1984, that (I) (we) last saw the deceased alive on 12/14, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Todd H. Hillman, MD								12/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Todd H. Hillman, MD		GBMC-6701 N. CHARLES ST.									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL		DEC. 17, 1984		ODD FELLOWS CEMETERY		CAMDEN		KENT		DEL.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
BARRANCO FUNERAL HOME		DEC 19 1984		541 RITCHIE HWY. SEVERNA PARK, MD							

BP _____



WILLIAMS COUNTY

CHARLES E. JONES

1960

RECEIVED 1960 JUL 13

1960 JUL 13

MULTIPLE YELLOW

X

1960 JUL 13

1960 JUL 13

1960 JUL 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

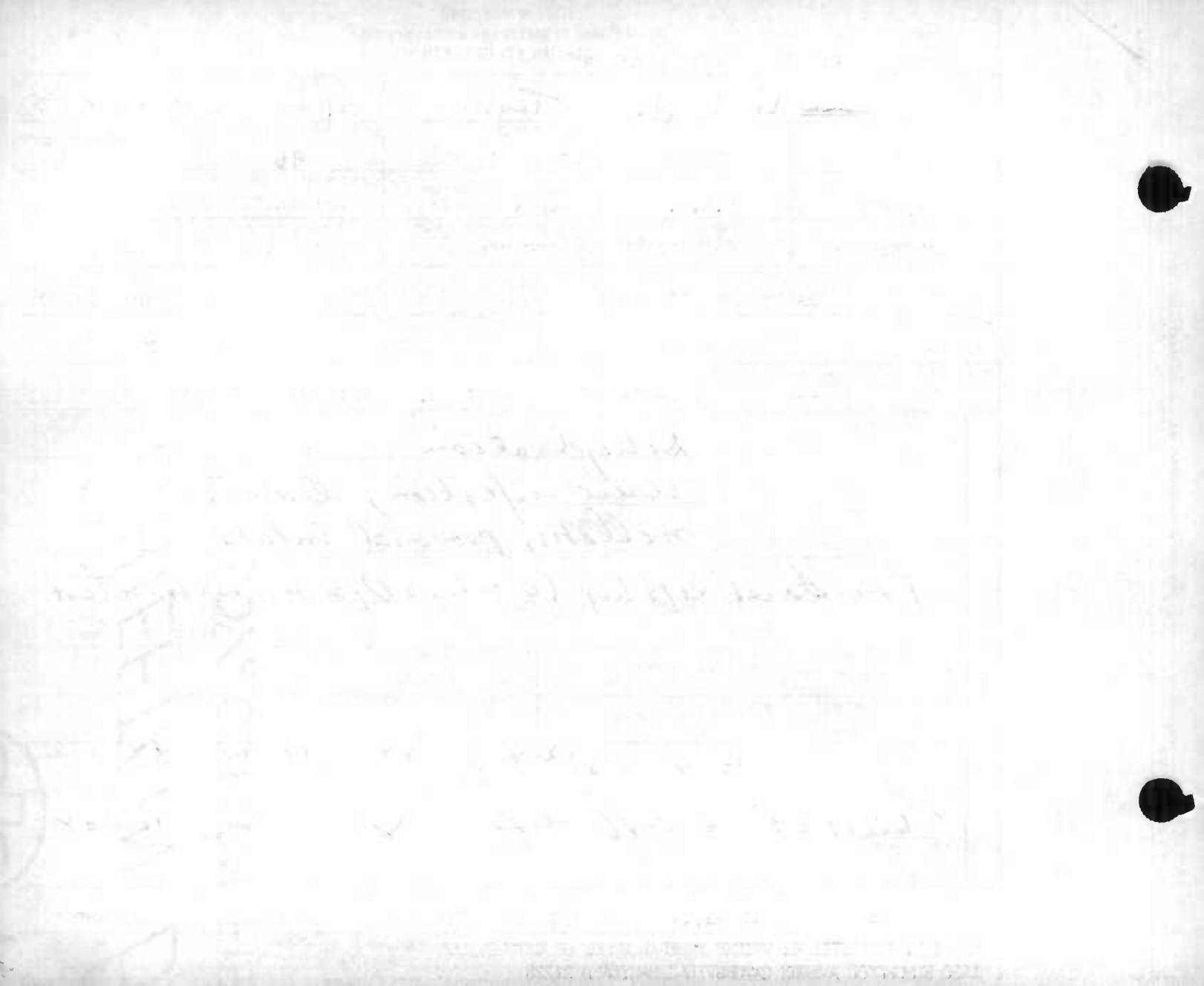
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

35 30 35 30 1

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR LILLIE MAY TAYLOR			3 2 3 5 7 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillie M. Taylor			2a. DATE OF DEATH MONTH DAY YEAR 12/10/84 12 10 84			2b. HOUR 5:50 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 14, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FOREST HAVEN NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN LOCHEARN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3726 PATTERSON AVENUE 21207	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN JACOBS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA (UNKNOWN)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS NORMAN R. TAYLOR 3726 PATTERSON AVENUE 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary infection, diabetes mellitus, poor oral intake</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fractured left hip (October 84), severe dementia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-4</u> 19 <u>84</u> , to <u>12-10</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-4</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE <u>Harold S. [Signature]</u> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 12-11-84			
27d. PHYSICIAN'S NAME (TYPE OR PRINT)				27e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOME OF CATONSVILLE 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 21228						25. DATA RECD. BY REGISTRAR 26. REGISTRAR'S SIGNATURE			

BP



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 5 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH G. TEITLER			2a. DATE OF DEATH MONTH DAY YEAR 12 26 84			2b. HOUR 6:20A_M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8 12 17		6. AGE (IN YEARS LAST BIRTHDAY) 67	
7a. BIRTHPLACE (STATE OR FOREIGN) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N CHARLES STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECTY		12b. KIND OF BUSINESS OR INDUSTRY US. GOVT.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL COHEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA KALICHSTEIN		16. STREET ADDRESS / ZIP CODE 6711 PARK HEIGHTS AVE. APT. 316 (21215)			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		18. SOCIAL SECURITY NO. 577-16-3650		19. INFORMANT ADDRESS ABRAHAM J. TEITLER 6711 PARK HEIGHTS AVE. APT. 316(21215)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE AND CHF DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED OVARIAN CA DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED OVARIAN CA							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from DEC 19 1984 to DEC 26 1984 , that (I/we) last saw the deceased alive on DEC 26 1984 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.							
22b. SIGNATURE <i>Walter Kobasa Sr MD</i>				DEGREE		22c. DATE SIGNED 12 26 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Kobasa Sr MD				22e. ADDRESS GBMC-N..CHARLES STREET-6701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEM. GDNS.		23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY, MONTGOMERY, MD.	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)				25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Rendell</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

RECEIVED
FBI
TELETYPE
JAN 24 1964

EX 12
C 12
JAN 17 1964

BALTIMORE COUNTY

CRIMINAL JUSTICE SYSTEM

RECEIVED
FBI
JAN 24 1964

ADVANCED BY R. W. C.

DEC 26 1963
DEC 26 1963
DEC 26 1963

DEC 26 1963

CRIMINAL JUSTICE SYSTEM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 5 9
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Stanley H. THOMAS			2a. DATE OF DEATH MONTH DAY YEAR December 13 1984			2b. HOUR 4:35 a.m.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 19 08	6. AGE (IN YEARS LAST BIRTHDAY) 76			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wales	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE, WORK OR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Electronics		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Zacharias Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Donne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-03-8443		17. INFORMANT ADDRESS Helen A. Thomas 1115 S. Bonsal St. 21224			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest; Poorly Differentiated DUE TO, OR AS A CONSEQUENCE OF Lung Adenocarcinoma (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ☒ (this hospital) attended the deceased from **November 26 1984** to **December 13 1984**, that ☒ (we) lost
saw the deceased alive on **December 13 1984**, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated
above, ☒ (we) did not view the body after death.

27b. SIGNATURE <i>[Signature]</i>	DEGREE	27c. DATE SIGNED 12-13-84
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric H. Kisa, M.D.	27e. ADDRESS 9000 Franklin Square Dr., 21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-15-84	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood, Balto. Co., Md.
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. 6224 Eastern Ave.		25. DATE REC'D. BY REGISTRAR DEC 14 1984 REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 with any injury, or other traumatic event, the medical examiner must be notified of cause.

12-17-44

City Loan Company

Eastern, Toledo, O., Inc.

1117-1119 Helen A. Thomas 1117 S. Forest St. 2124

Thomas Catherine

1117 South Forest Street 2124

Franklin Square Hospital

1117 S.

19 08 76

Thomas

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 3 6 0

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF ESTI- MATED			2b. DATE PRONOUNCED DEAD			2c. DATE PRONOUNCED DEAD			2d. HOUR		
JOHN CARTER THOMPSON			12-11-84			12-11-84			5:20A					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN									
Male	Negro	Mar. 17 1950	34 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia			U.S.A.						Baltimore County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Whitmarsh			I-95 nr. Rossville Blvd.			Truck Driver			Motor Freight					
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS					
Va. Chesterfield			Richmond			YES			3214 S. Battlebridge Drive					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Brooks Thompson			Rosa Willis											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			223-70-1703			Deloris Jackson Rt. 1 Trevilians, Va.								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries and thermal burns</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8120		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
	involved in a collision striking embankment & catching fire.	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5AM 12-11-84	21c. HOW INJURY OCCURRED driver of tractor trailer who struck another parked tractor trailer throwing victim from truck which caught fire.
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.	21f. STREET CITY OR TOWN COUNTY STATE I-95 nr Rossville Blvd. Whitmarsh, Maryland

22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 12-11-84
ACTUAL SIGNATURE <u>Margie Dore Hull</u>				
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Dec. 15, 84	Wayland Church Cemetery	Trevilians	Louisa County	Va.
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
John E. Thomas	P. O. Box 512 Louisa, Virginia 23093	DEC 17 1984	Julia Davidson-Rendall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

REEL 1 MORTON 2002

2002 MORTON 2002

0 2 5 3 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 4		3 2 3 6 1		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA V THOMPSON				2a. DATE OF DEATH MONTH DAY YEAR 12 23 84		2b. HOUR 6:10 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 15 11		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION GBMC 8701 N. CHARLES STREET 21204				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland -- Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 601 Harding Place 21211			
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --		16b. SOCIAL SECURITY NO. 219-10-6019		17. INFORMANT ADDRESS Mr. Richard Thompson 3021 Elm Ave. 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>84</u> to <u>12/23</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE TODD H. HILLMAN				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TODD H. HILLMAN				22e. ADDRESS GBMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME A. Blumertz				25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rodell			

BP

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THOMPSON V

BALTIMORE COUNTY

TOWSON CHASE STREET



RESERVATION E. LURE

12/23 12/23 12/23

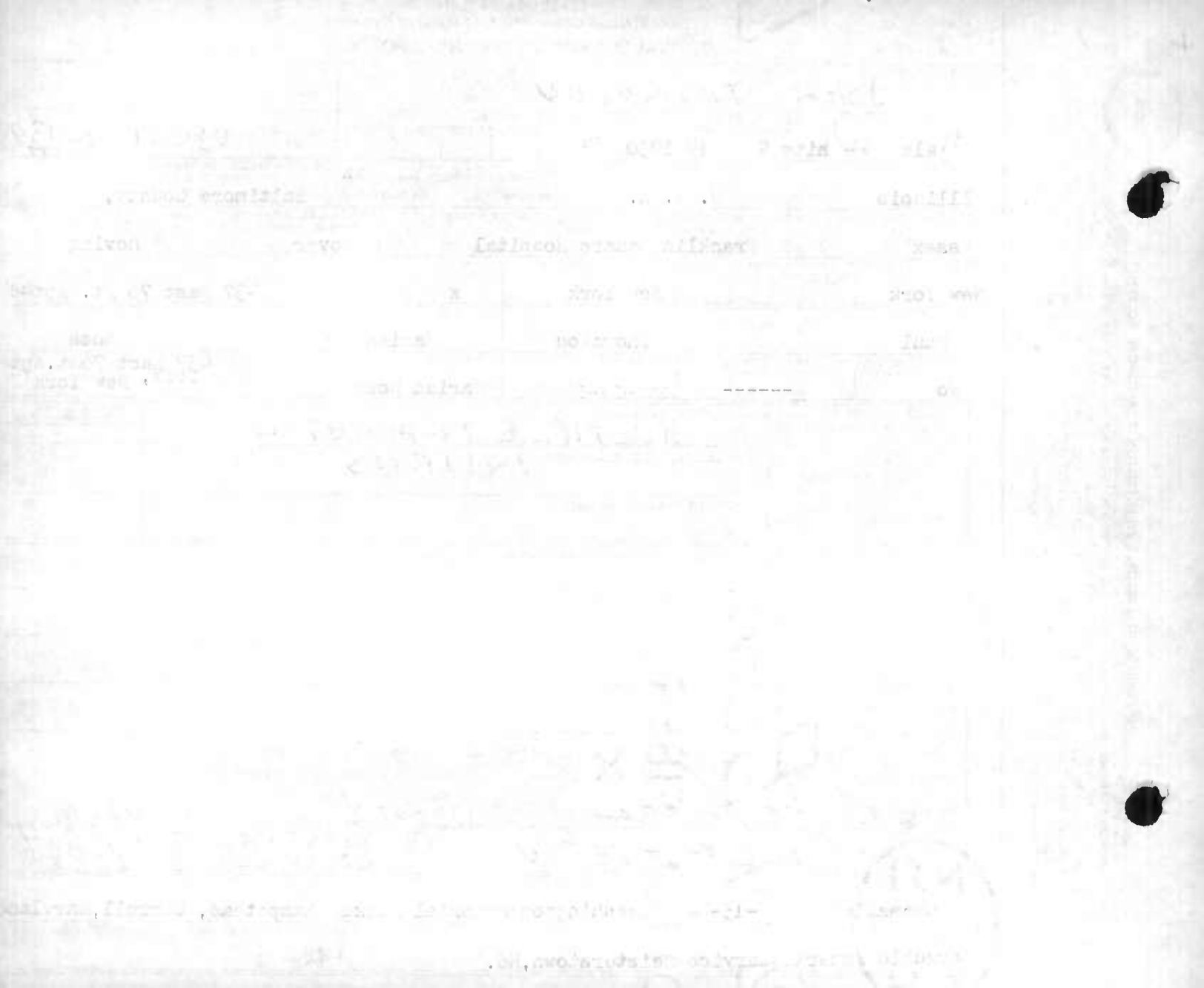
12/23/21

TODD H. MILLER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REMARKS SHOULD BE WRITTEN IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		3 2 3 6 2		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
JOHN THORNTON								19		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	
Male	White	9 19 1950		34 YRS.						DEC 11 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Illinois		U. S. A.				Baltimore County,		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Essex		Franklin Square Hospital		Mover		Moving					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
New York				New York		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		437 East 76 St. Apt 4d			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Paul		Marian		No		129-38-3895		Marian Moss		437 East 76 St. Apt 4d New York, New York	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) MULTIPLE TRAUMATIC INJURIES											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
PAUL R. GUYERIN		M.D. DEPUTY		DEC 11 1984							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1311 WESTERN RUN RD		COCISEYVILLE MD 21030					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Cremation		12-17-84		Carroll Cremation Services		Hampstead, Carroll, Maryland					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Marzullo Funeral Service		Reisterstown, Md.				DEC 14 1984		John Davidson			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 6 3 REG. NO.	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <u>MARY A. TINK BARN</u>						2a DATE OF DEATH MONTH <u>12</u> DAY <u>21</u> YEAR <u>84</u>		2b HOUR <u>3:00</u> PM	
3 SEX <u>FEMALE</u>		4 RACE <u>WHITE</u>		5 DATE OF BIRTH MONTH <u>8</u> DAY <u>15</u> YEAR <u>07</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.					
10 CITY OR TOWN OF DEATH <u>TOWSON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>STELLA MARIS Hospice</u>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <u>Maryland</u>		13b COUNTY <u>Baltimore</u>		13c CITY OR TOWN <u>Parkville</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <u>3110 Dubois Ave. 21234</u>			
14 FATHER'S NAME FIRST <u>Joseph</u> MIDDLE <u></u> LAST <u>Kalbfleisch</u>						15 MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u></u> LAST <u>Rodert</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>212-05-3696</u>		17 INFORMANT ADDRESS <u>Henry J Kalbfleisch 2478 Keyway 21222</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>OVARIAN CANCER</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>December 14</u> 19 <u>84</u> to <u>December 21</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>December 21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>McFaulkner</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FAULKNER</u>				22e. ADDRESS <u>STELLA MARIS Hospice</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Dec. 24, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>					
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Baltimore, Maryland</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 24 1984</u> REGISTRAR'S SIGNATURE <u>Guth Davidson-Rodert</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 3 6 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) RYLAND TOMLIN JR.				2a. DATE OF DEATH MONTH DAY YEAR 12 14 84			
3. SEX M MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 21 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 4/5 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FORK LIFT OPER.	
12b. KIND OF BUSINESS OR INDUSTRY SHIPSIDE PACKING							
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 7000 RUDISILL CT. APT 2A 21207			
14. FATHER'S NAME FIRST MIDDLE LAST RYLAND TOMLIN, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE LOGAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 223 28 4918		17. INFORMANT ADDRESS APT. 2A 21207 MRS. JANIE MAE TOMLIN 7000 RUDISILL CT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ASYSTOLE DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK & severe thrombocytopenia DUE TO, OR AS A CONSEQUENCE OF (c) INTRACEREBRAL HAEMORRHAGE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) METASTATIC CARCINOMA or Acute Leukemia Bronchopneumonia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (i) (we) last saw the deceased alive on _____ 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hafeez A. Syed				22c. DEGREE Pathologist		22d. DATE SIGNED 12/15/84	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEEZ SYED				22f. ADDRESS BALTIMORE COUNTY GEN HOSP			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/20/84		23c. NAME OF CEMETERY OR CREMATORY WILLIE CHAPEL BAPT.		23d. LOCATION CITY OR TOWN COUNTY STATE LANCASTER (LANCASTER) VA.	
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN				ADDRESS 4517 PARK HEIGHTS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 18 1984	
				25b. REGISTRAR'S SIGNATURE John Davidson Handell			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as fatal, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 6 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eileen F. Toohey			2a. DATE OF DEATH MONTH DAY YEAR 12-19-1984			2b. HOUR 12:30 A.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 14 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riverview Nursing Home				12a. USUAL OCCUPATION (TYPE AND INDUSTRY FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto 13c. CITY OR TOWN Stoneleigh					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE 7115 Rich Hill Rd. 21212	
14. FATHER'S NAME FIRST MIDDLE LAST John P. Fitzgerald				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia McCormick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 218 36 4369		17. INFORMANT ADDRESS Mrs Eileen Dee Schneid Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN 10 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from April 22, 1982, to Dec 19, 1984, that (I) (we) lost the deceased alive on 19 Nov. 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Morris Rainess M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/19/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morris Rainess M.D.					22e. ADDRESS 1105 OLD EASTERN AVE Balto Md 21211						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/21/1984		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto Md				
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Rd.						25a. DATE REC'D. BY REGISTRAR 21 1984		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall			

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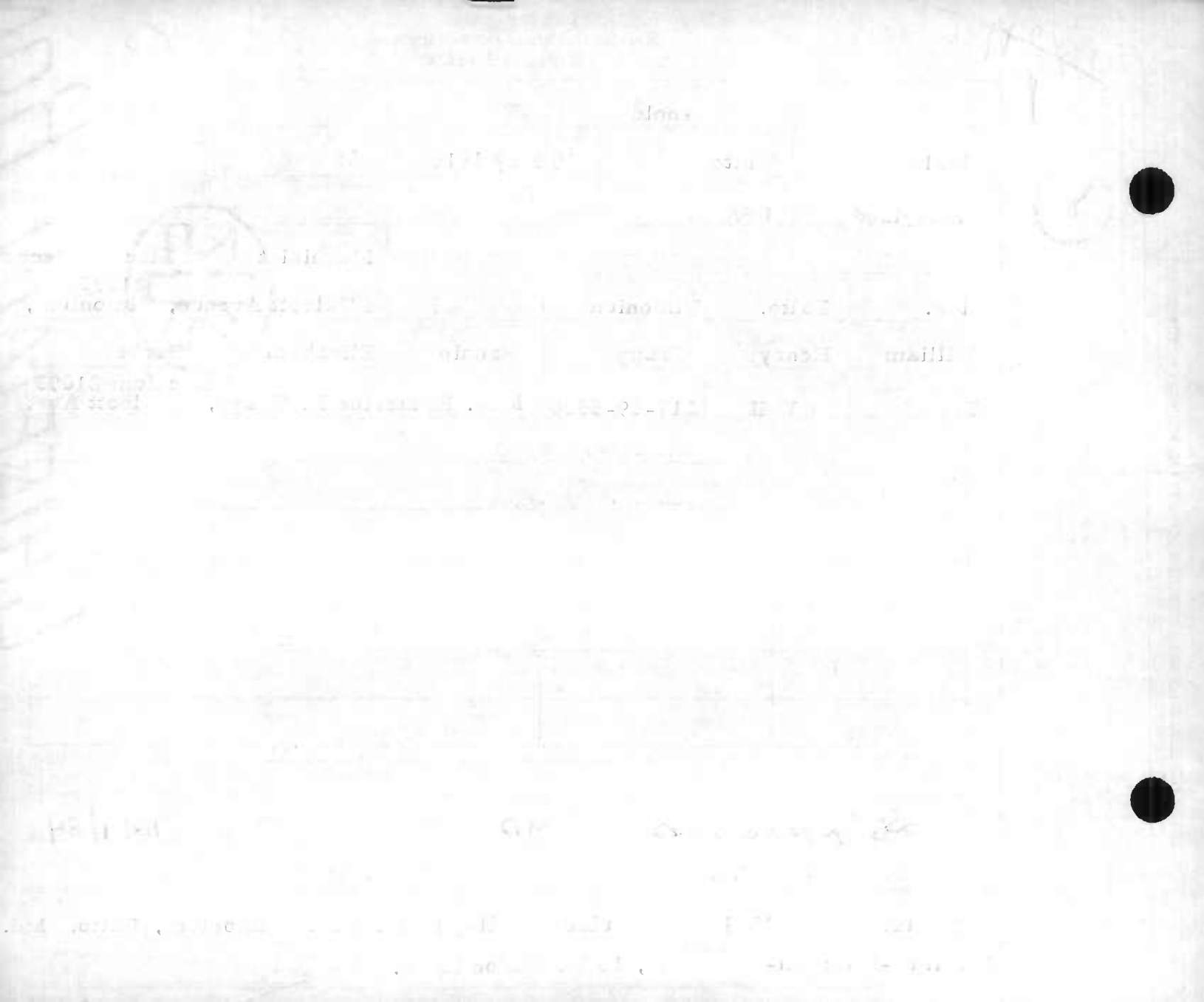
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR		3 2 3 6 6		REG. NO.					
1. DECEASED NAME (LAST, FIRST, MIDDLE) HENRY Arnold TRAPP				2a. DATE OF DEATH MONTH DAY YEAR 12 11 '84		2b. HOUR 11:08^A_M			
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 19 May 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Black & Decker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY Balto.		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4 Talbott Avenue, Timonium, 21093	
14. FATHER'S NAME (FIRST, MIDDLE, LAST) William Henry Trapp				15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) Nannie Elizabeth Gerber					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 217-09-5550		17. INFORMANT ADDRESS Mrs. Katherine L. Trapp, 4 Talbott Ave. Timonium 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) MULTIPLE MYELOMA (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/27 , 19 84 , to 12/11 , 19 84 , that (I) (we) last saw the deceased alive on 12/11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Diane Pappas</i>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DIANE PAPPAS, M.D.				22e. ADDRESS GBMC - 6701 N. CHARLES STREET 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Balto. Md.			
24. FUNERAL DIRECTOR <i>Martin D. Lawson</i>				25a. DATE REC'D. BY REGISTRAR DEC 12 1984		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Henderson</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		3 2 3 6 7	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIA TRAVAGLINE		2a. DATE OF DEATH MONTH DAY YEAR 12 11 84 2b. HOUR 1:10P M	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7 16 94	
6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH DUNDALK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NRSG. CTR. - HERITAGE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. CITY OR TOWN BALTO	
14. FATHER'S NAME FIRST MIDDLE LAST PATERRA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGDALINA UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 213-74-8206	17. INFORMANT RICHARD TRAVAGLINE ADDRESS 3512 ADY RD BALTIMORE MD 21132	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) C A Lung DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 81 , to 12/11 , 19 84 , that (I) (we) lost saw the deceased alive on above (I) (we) (did) (did not) sew the body after death.			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. T. PATTERSON		22c. DATE SIGNED 12/11/84	
22d. ADDRESS 3427 DUNDALK AVE., BALTIMORE, MD 21222		22e. SIGNATURE Thos Patterson M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/14/84	
23c. NAME OF CEMETERY OR CREMATORY DAK LAWN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME ADDRESS RAYMOND L. KACZOROWSKI, 2525 FLEET STREET		25a. DATE REC'D. BY REGISTRAR DEC 13 1984	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall		25c. REGISTRAR'S SIGNATURE	



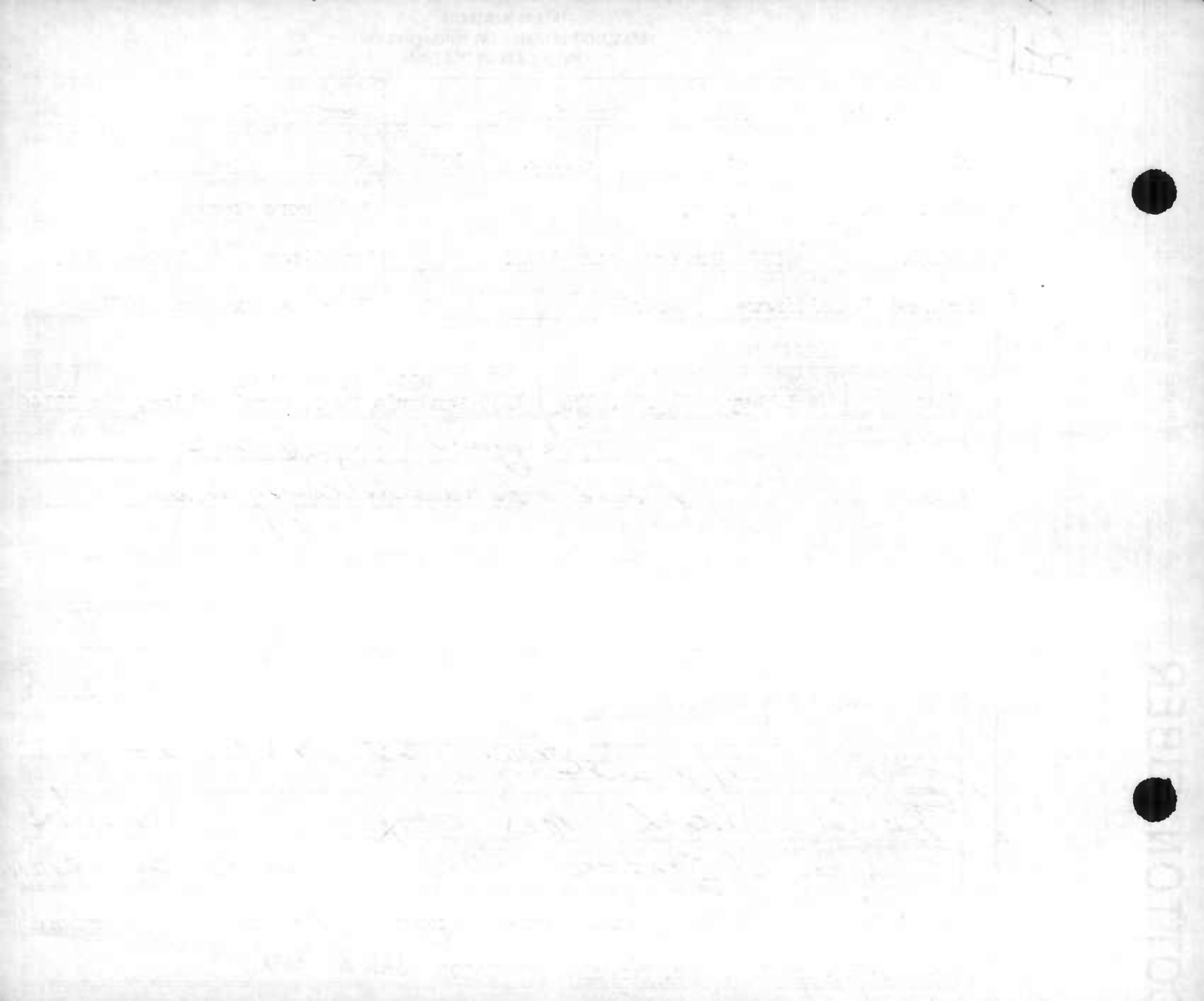
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 3 6 8			
1. DECEASED NAME (TYPE OR PRINT) Louis rmi Trischmann				2a. DATE OF DEATH MONTH DAY YEAR December 27, 1984			
3. SEX Male				2b. HOUR 1:00A M			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 29, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2902 Dunmore Road 21222		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Expediter		12b. KIND OF BUSINESS OR INDUSTRY Paint Mfg.	
13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I Navy 216.01.9375		17. INFORMANT ADDRESS Ellen G. Sessions 1230 Mendavia Ave., Coral Gables, Fla 33146			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i></i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/27/84 to 12/28/84, that (I) (we) lost saw the deceased alive on 12/27/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)							
22b. SIGNATURE <i>Charles J. Blazek</i> M.D.				22c. DATE SIGNED 12/28/84		22d. PHYSICIAN'S NAME (PRINT) CHARLES J. BLAZEK	
22e. ADDRESS 3910 KESWICK RD BALTO 21211				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/29/1984		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 2 1985			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 filled in.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 3 6 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARMENE TROIA				2a. DATE OF DEATH MONTH DAY YEAR 12 31 84			
2b. HOUR 12 45 AM							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY VIEW NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESSER		12b. KIND OF BUSINESS OR INDUSTRY L2 Bow BRS.	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST Luigi TROIA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA G. LANDIA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212 46 5511		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma DUE TO, OR AS A CONSEQUENCE OF (b) Brain stem infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cerebellar degeneration rigidity - HBP.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (third person) attended the deceased from 12/28/84 to 12/31/84 that (I) (we) last saw the deceased alive on 12/28/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) signed did not view the body after death)							
22b. SIGNATURE [Signature]				22c. DEGREE DEGREE		22d. DATE SIGNED 12/31/84	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY DUBLANSKY VALLEY		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS CHAPL OF CHIMES				24b. ADDRESS 2325 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 7 1985	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

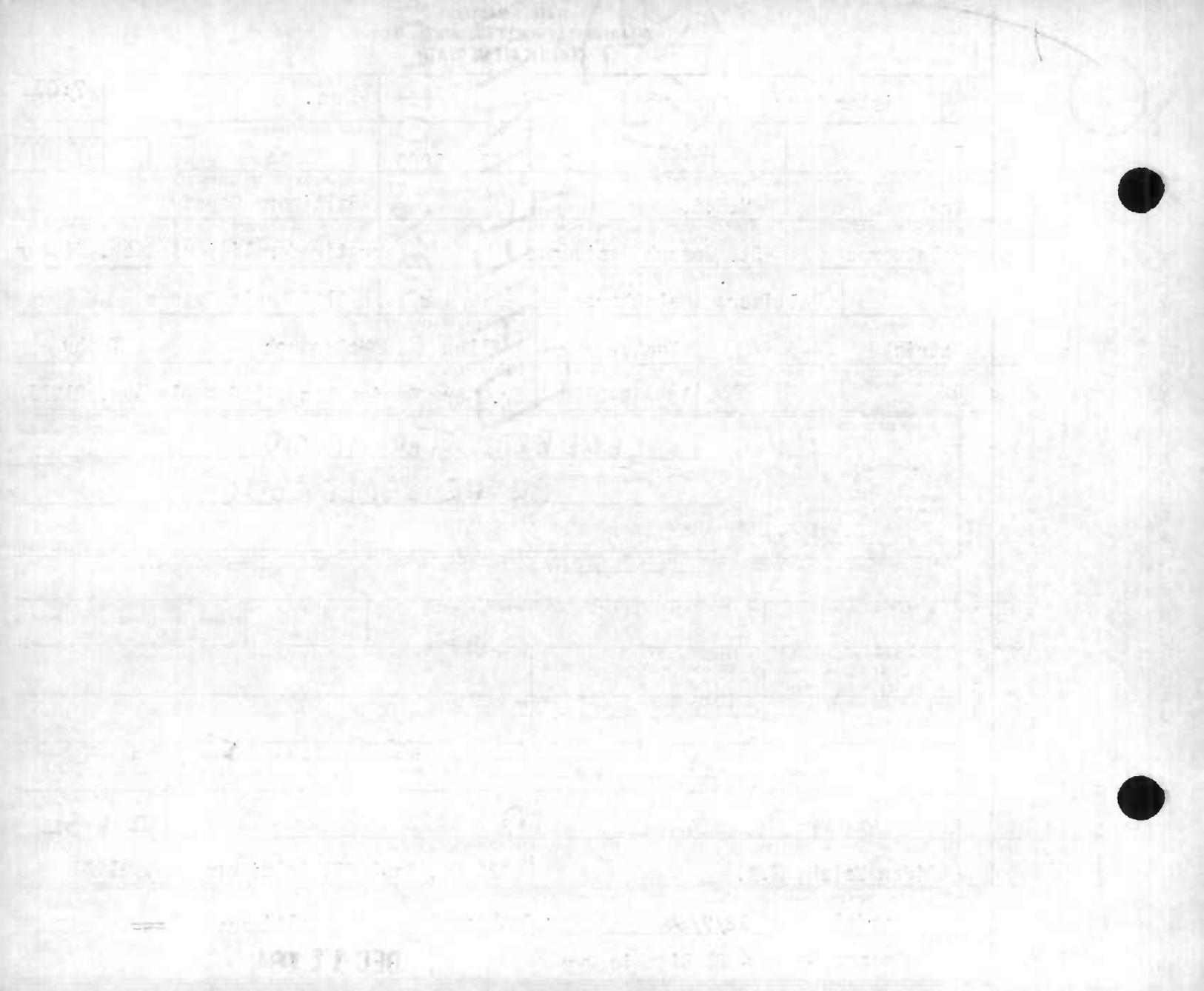
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 7 0 REG. NO.			
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) Sister Mary Margaret Tuohy										2a. DATE OF DEATH MONTH DAY YEAR Dec. 5 84		2b. HOUR MIN 7:01P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 27 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Halethorpe		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Residence				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired religious		12b. KIND OF BUSINESS OR INDUSTRY Cath. Sister					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4100 Maple Avenue 21227	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Halethorpe									
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Tuohy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen McDonough Tuohy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 199-40-8880		17. INFORMANT ADDRESS Sr. Mary Regina Long, 4100 Maple Ave. 21227									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19 84 , to 12-5-84 , that (I) (we) last saw the deceased alive on Sept. 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Aidan E. Walsh DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-6-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aidan Walsh, M.D.				22e. ADDRESS 333 St. Paul Pl., Baltimore, Md. 21202									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN Baltimore COUNTY == STATE MD							
24. FUNERAL DIRECTOR NAME George Gonce ADDRESS 4001 Ritchie Hwy				25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE [Signature]							

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Page 4 may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 4 and 5 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 3 7 1			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALMA M. VANDERMAST				2a. DATE OF DEATH MONTH DAY YEAR December 2, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1891		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 93	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 423 Oak Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. County	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Maryland Baltimore Towson				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 423 Oak Lane 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest W. Vandermast				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma C. Schaaake			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216-18-9927		17. INFORMANT ADDRESS Frederick W. Vandermast-4009 Eland Rd. 21131	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <u>CARDIO pul. Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arterio Sclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14.4 YRS YRS YRS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: - <u>Sensitivity</u> - <u>osteoporosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (the hospital) attended the deceased from <u>6-21</u> , 19 <u>78</u> , to <u>Dec 2</u> , 19 <u>84</u> , that (1) (we) lost saw the deceased alive on <u>11-27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> M.D. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. J. Venable, Jr. M.D.				22e. ADDRESS 7215 York Road, Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-4-84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 7 2
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Henry VonBehren			2a. DATE OF DEATH MONTH DAY YEAR December 15, 1984			2b. HOUR M M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 12, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Plumber		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick W. VonBehren			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth M. Saalbach			13e. STREET ADDRESS / ZIP CODE 5911 Burgess Ave. 21214			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Navy WW I 213-01-2655		17. INFORMANT ADDRESS Helen A. Walter 6604 Glenoak Ave. 21214				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension & depression DUE TO, OR AS A CONSEQUENCE OF (c) Asphyxiation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a 3. State pneumonia removal									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE NATURE OF ACCIDENT)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> FACE WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/11/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE Dr. Donald W. Mintzer			22c. DEGREE M.D.			22d. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 12/17/84	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald W. Mintzer M.D.			22g. ADDRESS 3009 Evergreen Ave. Balt., Md. 21214						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Dec 18 1984		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland					25a. DATE REC'D. BY REGISTRAR DEC 19 1984		25b. REGISTRAR'S SIGNATURE [Signature]		

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

RECEIVED
JAN 10 1964
FBI
WASHINGTON, D.C.

Investigation of

Investigation

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Jan. 10, 1964

White

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Re: [illegible]

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U.S.A.

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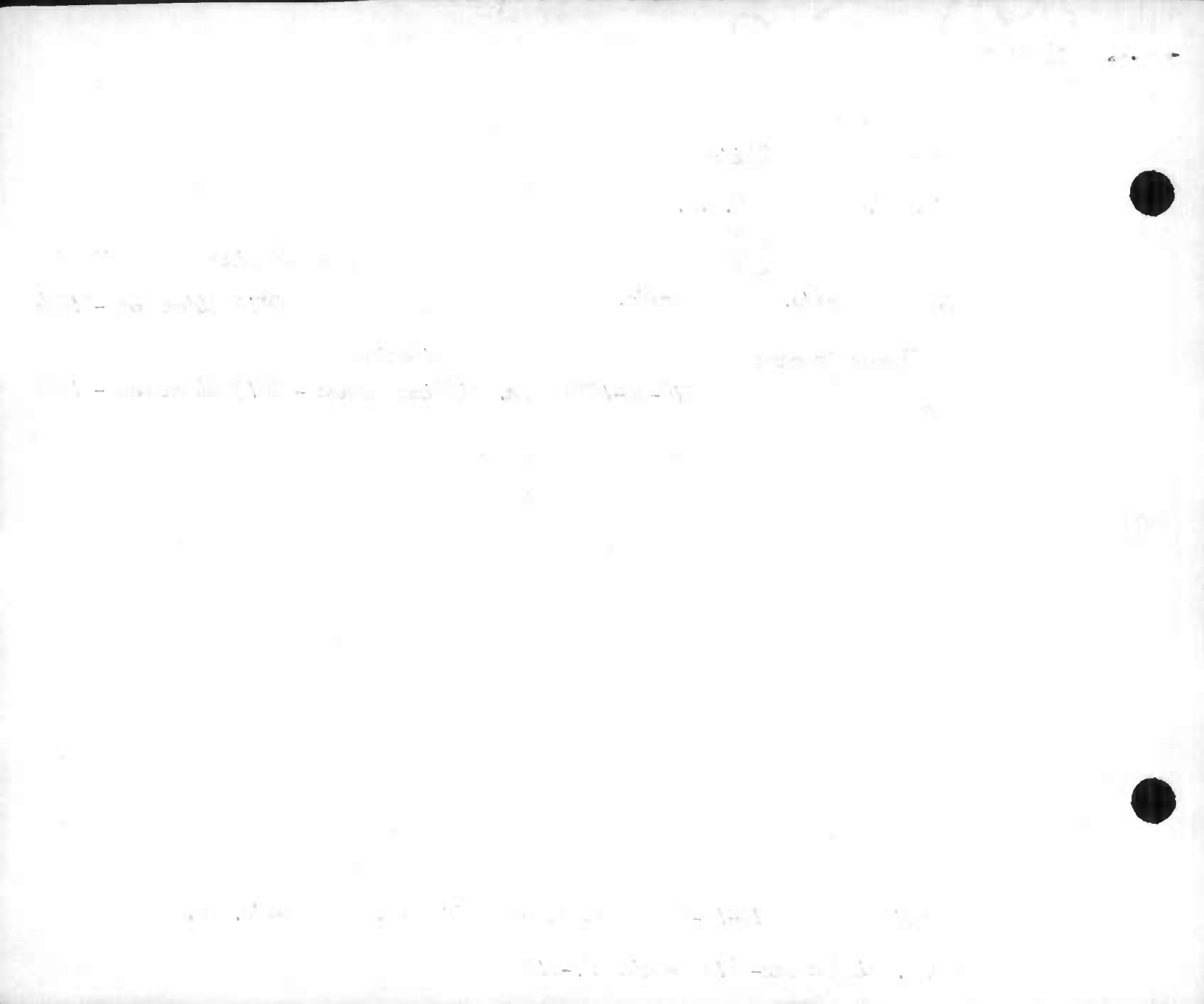
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 7 3
REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Beatrice G. Wagner		12 14 84		10:25h	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12 12 06		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Line		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas McManus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine		17. INFORMANT ADDRESS Mr. William Wagner - 2813 Alden Road-21234			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-20-1959					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF 1b) <u>CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF 1c) <u>CARCINOMA OF LEFT LUNG WITH METASTASES</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (us) (d) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-15-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REYNALDO ORJUELA-GOMEZ, M.D.		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-18-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
				DEC 17 1984			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 3 7 4 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Gertrude Wagner										2a. DATE KNOWN OF DEATH MONTH DAY YEAR December 26 1984		2b. HOUR MIN 12:25 PM							
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 25, 1890		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 94		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR December 26 1984		2d. HOUR MIN 12:25 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		MD.					
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2810 Gibbons Ave 21214			
14. FATHER'S NAME FIRST MIDDLE LAST John J. Wehner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Basil				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-74-7358				17. INFORMANT ADDRESS Mr Leroy A Wagner 4308 Meadows Cliff Rd 21057			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-7 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Charles F O'Bonnell</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED 12/26/84							
EXAMINER'S NAME (TYPE OR PRINT) Charles F O'Bonnell M.D.				ADDRESS 7501 York Rd Towson, Maryland															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/29/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland									
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc.						ADDRESS Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE <i>Arlene Davidson-Randall</i>							

BP

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 7 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		12 14 84		2:50PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		White		May 30, 1903		81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		GBMC 6701 N. CHARLES ST.		Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
William		Carrie		1109 Chatterleigh Circle		21204	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		217-22-5680		M. Margaret Tolson		21204 1109 Chatterleigh Circle	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRO VASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROSIS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/04</u> , 19 <u>84</u> , to <u>12/14</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
DR EMILIO LOBATO				GBMC 6701 N CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Dec 17 1984		Gardens of Faith		Baltimore Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland				DEC 17 1984			

W 2:50P

W 2:50P

W 2:50P

BALTIMORE COUNTY

68MC 6701 W. CH BLES ST.

TOWSON

ACUTE RESPIRATORY FAILURE

CEREBRO VASCULAR ACCIDENT

THROMBOCYTOSIS

BA

SA

SA

SA

SA

SA

68MC 6701 W. CH BLES ST.

CR EMILIO LOB TO

W 2:50P

W 2:50P

W 2:50P

W 2:50P

W 2:50P

W 2:50P

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

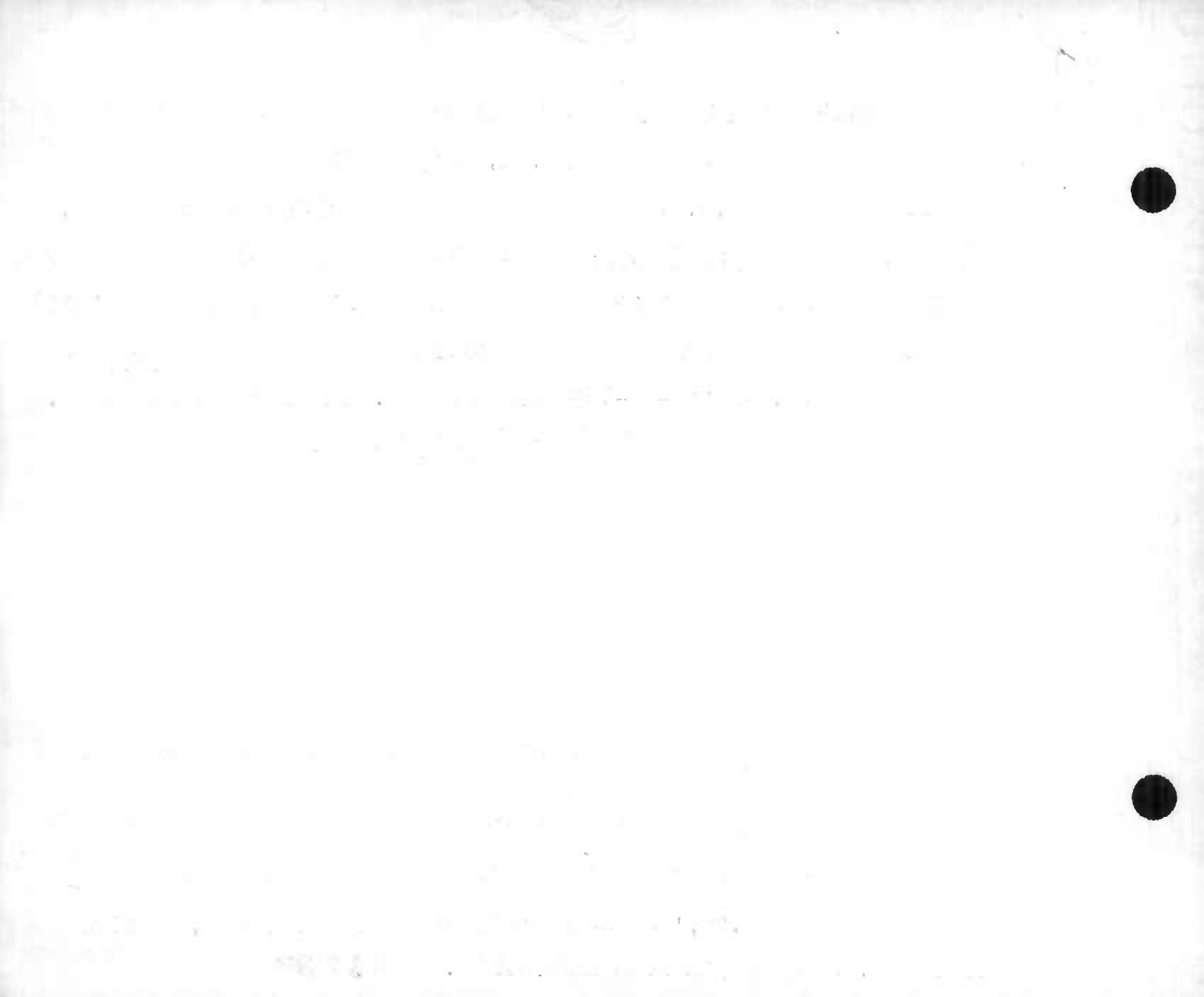
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 3 7 6

1. DECEASED NAME (TYPE OR PRINT) BERNARD D WALDEN			2a. DATE OF DEATH MONTH DAY YEAR 12-25-84		2b. HOUR 5:00 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 1, 1925	6. AGE (IN YEARS (LAST BIRTHDAY)) 59 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHEET METAL	12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE	13c. CITY OR TOWN 21234	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8718 JENIFER ROAD 21234
14. FATHER'S NAME FIRST MIDDLE LAST DAVID WALDEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE KNOEDLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 220-18-4650		17. INFORMANT ADDRESS 21234 KATHERINE M. WALDEN 8718 JENIFER RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) (this hospital) attended the deceased from 12-18 , 19 84 , to 12-25 , 19 84 , that (X) (we) lost the deceased alive on 12-25 , 19 84 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Maurice B Furlong Jr MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-26-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURICE B FURLONG JR			22e. ADDRESS 7620 - YORK RD TOWSON MD 21204		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE DEC. 27, '84	23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON			25a. DATE REC'D. BY REGISTRAR DEC 27 1984		
ADDRESS 8521 LOCH RAVEN BLVD.			25b. REGISTRAR'S SIGNATURE Guth Davidson Randall		

BP



BP. _____
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 3 7 7	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE R. WALKER			2a. DATE OF DEATH MONTH DAY YEAR 12 13 84		2b. HOUR 6 A M
1. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 12 28 06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO, CT. MD.	
10. CITY OR TOWN OF DEATH BALTO. Co.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4417 Hershey Way, 21236		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	
13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5 Breat Ct. 21221
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES CRIMI			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE IPSARO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-10-1171		17. INFORMANT ADDRESS Mr. Harry C. Walker - 4417 Hershey Way, 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) malignant pericardial effusion DUE TO, OR AS A CONSEQUENCE OF (c) adenocarcinoma, lung					3 mo. 23 1/4 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from January , 19 83 , to December , 19 84 , that (I) (we) <input checked="" type="checkbox"/> last saw the deceased alive on November 30 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Louise B. Grochow		DEGREE M. D.		22c. DATE SIGNED 12/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUISE B. GROCHOW		22e. ADDRESS 600 N. Wolfe St., BALTO MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.		23e. DATE REC'D. BY REGISTRAR DEC 17 1984			
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206		24b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

1711-1-15

DATE - 08/09/2016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with an original per death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-7000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 7 8			
1- FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
Irene						Warfield		12		9	84	2:40am	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))		7 UNDER 1 YEAR		7 UNDER 24 HRS			
Female		White		MONTH DAY YEAR 9 20 1892		92 YRS.		MONTHS DAYS		HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Presbyterian Home		12a USUAL OCCUPATION (IF NOT IN BUSINESS OR MOST OF WORKING LIFE) HAR MAKER		12b KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 108 N. Luzerne 21224					
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Henry Warfield		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Louise Riechhardt											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b SOCIAL SECURITY NO. 212-03-0153		17 INFORMANT ADDRESS Mrs. Robertson 400 Georgia Ct. 21204									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PUL Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovasc. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>714</u> <u>YRS</u> <u>YRS</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Sens. lity</u>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from <u>6-19-80</u> to <u>12-9-84</u> , that (I) (we) lost saw the deceased alive on <u>12-5-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Dr. S.J. Venable</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>12-10-84</u>							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S.J. Venable		22e ADDRESS 7215 York Rd.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/8/84		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt.		23d LOCATION CITY OR TOWN COUNTY STATE Balto. Md.							
24 FUNERAL DIRECTOR Mitchell-Wiedefeld		6500 York Rd.		25a DATE REC'D. BY REGISTRAR DEC 12 1984		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) REGINA (JEAN) WASHBURN			2a. DATE KNOWN OF DEATH December 31 1984		2b. HOUR 5 P.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 1 DAY 23 YEAR 20	6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	7. DATE PRONOUNCED DEAD December 31 1984
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10316 Malcolm Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD		13b. CITY OR TOWN Baltimore Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10316 Malcolm Ct., 21030
14. FATHER'S NAME FIRST Charles MIDDLE LAST Woody			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Falter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 213 18 6707		17. INFORMANT David E. Washburn, ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erysipelas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Carcinoma of Esophagus (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH Sudden 1 1/2 yrs						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE Charles O' Donnell M.D.		DATE 12/31/84		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Charles O' Donnell		ADDRESS 7501 York Road, Balto., MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR JAN 2 1985		
				25b. REGISTRAR'S SIGNATURE Davidson-Randall		

Handwritten notes in the top right corner, including a circled 'C' and some illegible text.

Yours truly,
Charles L. Connelley
10010 Wilshire Blvd., Suite 100
Beverly Hills, California 90210
Tel. (310) 205-1234
Fax (310) 205-5678

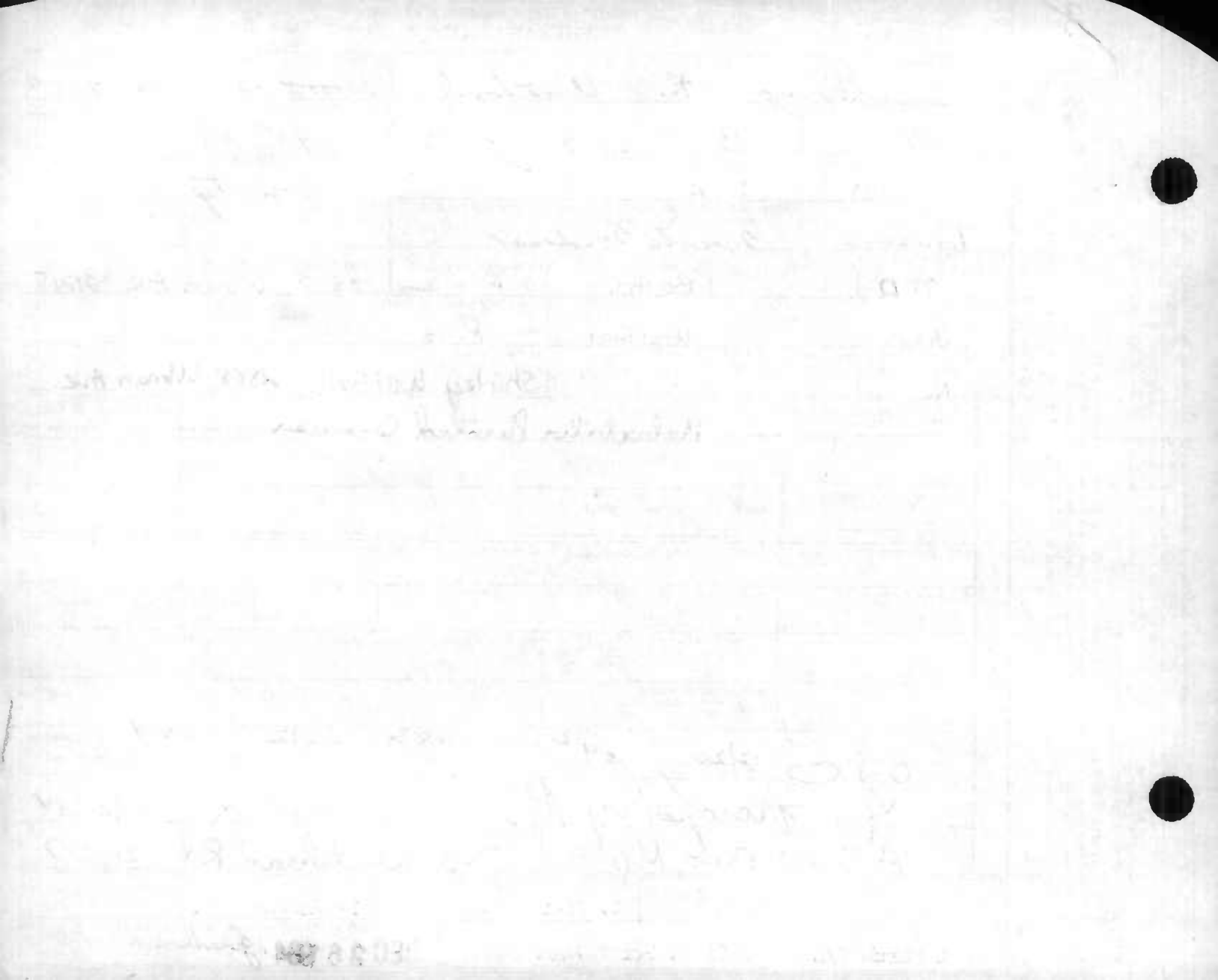
[Faint, mostly illegible handwritten text, possibly a letter or memo.]

Charles L. Connelley
10010 Wilshire Blvd., Suite 100
Beverly Hills, California 90210
Tel. (310) 205-1234
Fax (310) 205-5678

1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 3 8 0 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) George R. Watford				2a. DATE OF DEATH MONTH DAY YEAR 12/21/84	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 23 39	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi Medical		9. BALTIMORE CITY OR COUNTY OF DEATH County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 2808 Ulman Ave 21215	
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Ruth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216/36/8746		17. INFORMANT ADDRESS Shirley Watford 2808 Ulman Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Prostatic Cancer DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/20/84 to 12/21/84, that (I) (we) last saw the deceased alive on 12/20/84 and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.					
22b. SIGNATURE A. Shorofsky MD		22c. DATE SIGNED 12/21/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) A SHOROFSKY MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.	
24. FUNERAL DIRECTOR NAME Wm C March F/H		1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 26 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

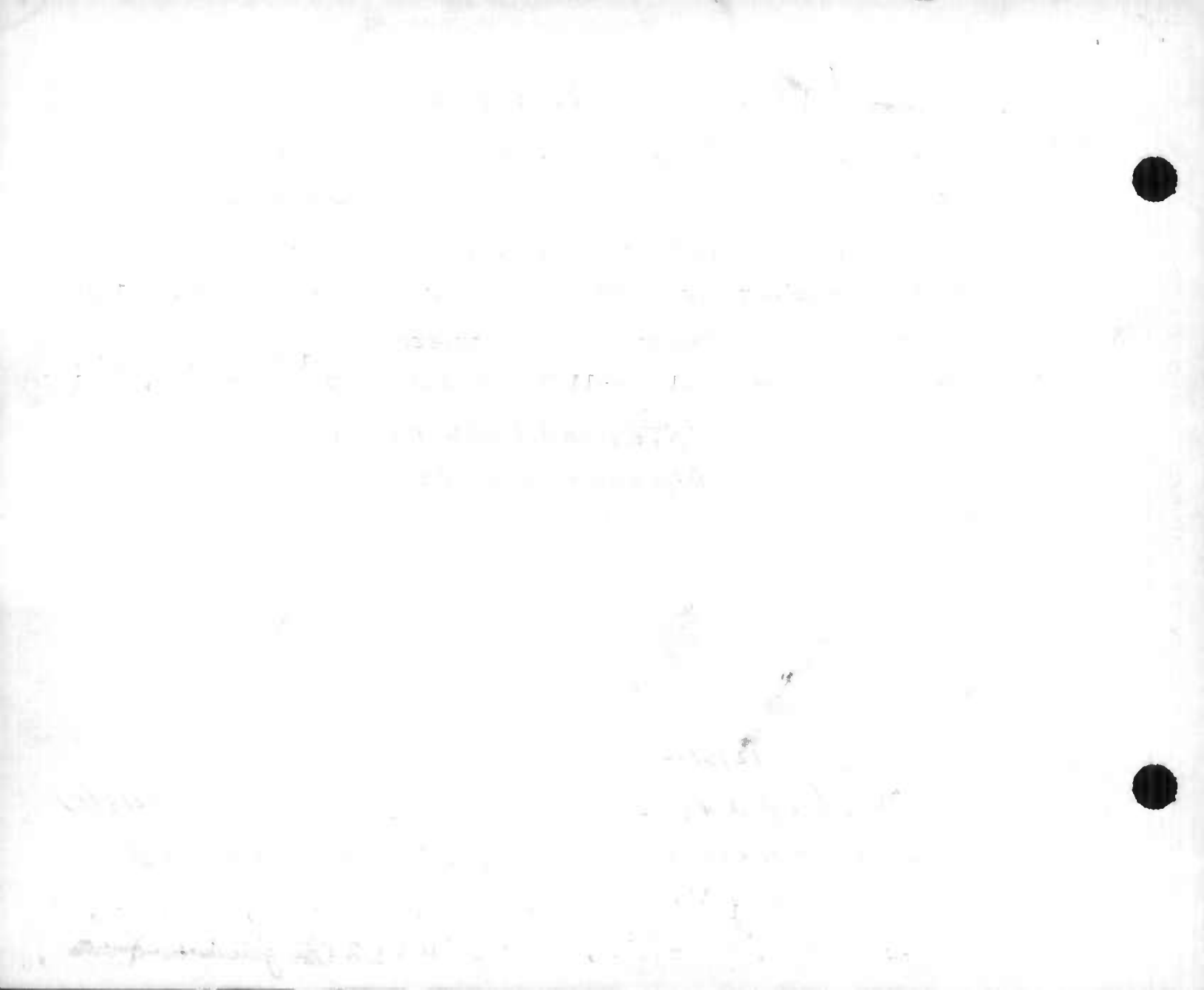


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 8 1 REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 12-8-84 4:15 PM						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernice v. WEAVER					3. SEX Female						
4. RACE White					5. DATE OF BIRTH MONTH DAY YEAR 09 12 98						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland					7b. CITIZEN OF WHAT COUNTRY? USA						
10. CITY OR TOWN OF DEATH Towson					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE Ruxton						
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife					12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. STATE Maryland					13b. CITY OR TOWN Baltimore						
13c. CITY OR TOWN Freeland					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13e. STREET ADDRESS / ZIP CODE Valley Mill Rd. 21053					14. FATHER'S NAME FIRST MIDDLE LAST Frank Cooper						
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Baker					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						
16b. SOCIAL SECURITY NO 215-54-1177					17. INFORMANT ADDRESS 120 Highland Ave. Margaret Boyer New Freedom, PA 17349						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>DEHYDRATION - ELECTROLYTE IMB.</u> (c) <u>EX HIP.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>12/6/84</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I) (and) view the body after death.											
22b. SIGNATURE <u>[Signature]</u> DEGREE								22c. DATE SIGNED <u>12/8/84</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. E. PARRA</u>								22e. ADDRESS <u>7122 HARFORD Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Parkton, Baltimore, MD		
24. FUNERAL DIRECTOR NAME J. J. Hartenstein, New Freedom, PA 17349								25a. DATE REC'D. BY REGISTRAR 12 12 1984			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											



1- FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8 4

REG. NO. 3 2 3 8 2

1. DECEASED NAME (TYPE OR PRINT) Dorothy Anna WEGMANN			2a. DATE OF DEATH MONTH DAY YEAR December 3, 1984		2b. HOUR 7:20 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov 5 1907	6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
11. CITY OR TOWN OF DEATH Balto.		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6716 Belair Road 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Christian J. Hahner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Dangler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 089-32-9516	17. INFORMANT Warren Danna ADDRESS 7 Timberview Ct. Kentucky		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe Phnomia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:to					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the decedent from December 1, 1984 to December 3, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 3, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Taylor		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Taylor		22e. ADDRESS 9000 Franklin Sq Dr.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 6, 1984	23c. NAME OF CEMETERY OR CREMATORY Nassau Knolls Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Port Wash. N.Y.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland		ADDRESS DEC 5 1984		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Wenderson Pender	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified.

BP



W. H. H. V.

W. H. H. V.

W. H. H. V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

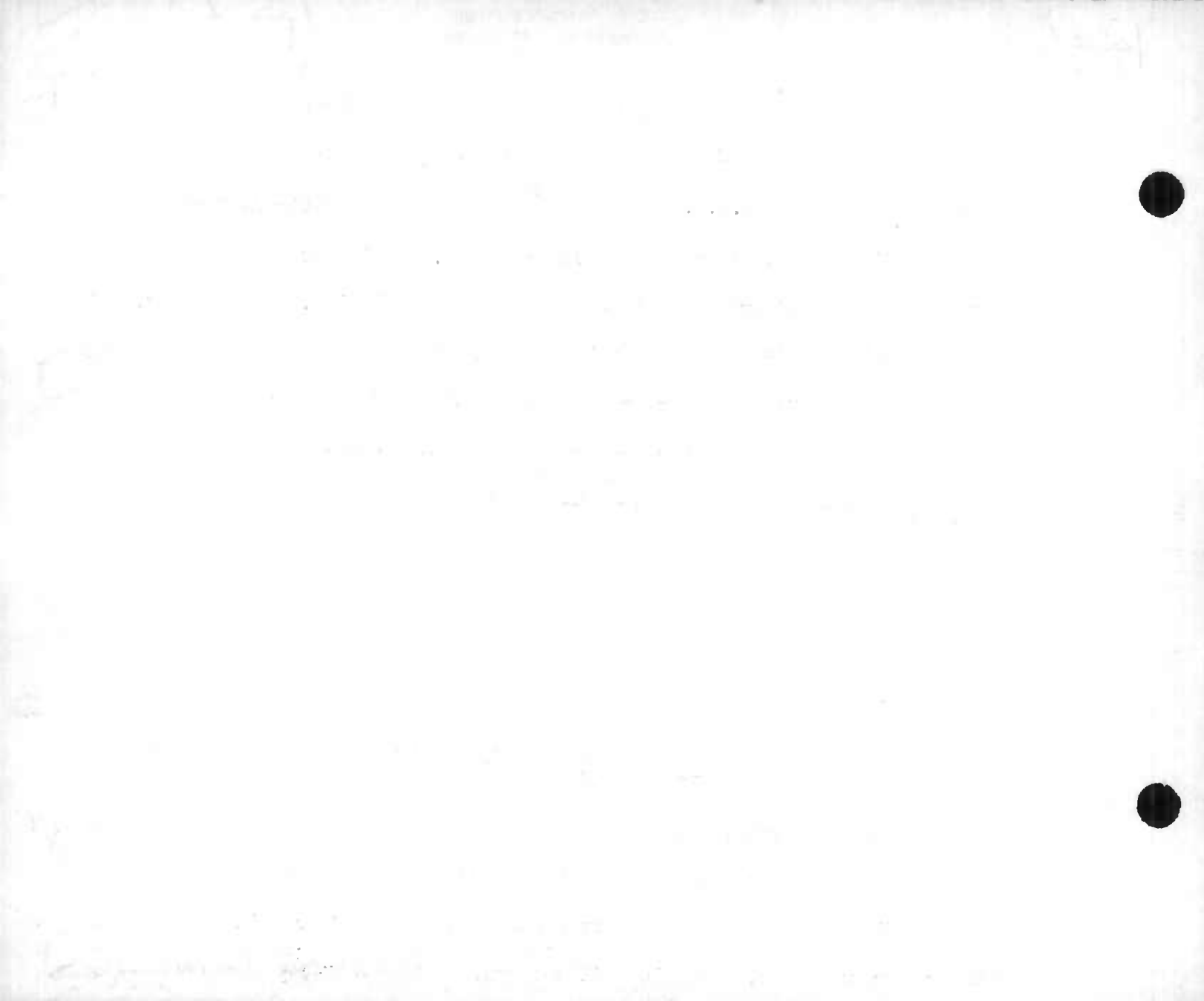
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 3 8 3	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MICHAEL ROBERT WEISENGOFF						2a. DATE OF DEATH MONTH DAY YEAR Dec. 23, 84		2b. HOUR 5:20 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 26 1930		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Planner		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1757 C. Champlain Dr. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Michael Weisengoff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Mazioka							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT 213-30-2304		ADDRESS Paul Weisengoff 1904 Griffis Ave. 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 23, 1984</u> to <u>Dec. 23, 1984</u> , that (I) (we) last saw the deceased alive on <u>Dec. 23, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Sharon Pounmotabbes, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-23-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM POUNMOTABTES				22e. ADDRESS Balt. Co. General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Baltimore Md.					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				24. FUNERAL DIRECTOR ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR DEC 26 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u>			

BP



FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Carrie Weller		2a. DATE OF DEATH MONTH DAY YEAR 12 18 84		2b. HOUR 5 P M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 4 1882		6. AGE (IN YEARS LAST BIRTHDAY) 102 ? YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto Md-USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto Co MD.	
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bland Bryant		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 700 S. Charles Street
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-54-4414		17. INFORMANT ADDRESS Hosp Chart Spring Grove State	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Generalized Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Organic Brain Syndrome - Dementia - Hx. of Schizophrenia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-30-1977 to 12-18-1984 , that (I) <input checked="" type="checkbox"/> was lost saw the deceased alive on 12-18-1984 , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE Dr. Cesar Valle Cervero M.D.		DEGREE M.D.		22c. DATE SIGNED 12-18-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR VALLE CERVERO		22e. ADDRESS Spring Grove Hospital Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Pk	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.					
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville Md		25a. DATE REC'D. BY REGISTRAR DEC 21 1984	
				25b. REGISTRAR'S SIGNATURE Richard J. Fendall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 8 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary J. Welsh			2a. DATE OF DEATH MONTH DAY YEAR December 4, 1984			2b. HOUR M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Pawson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1205 Robin Hood Circle				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY ✓		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3014 Parkside Drive 21214	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Ponkow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Sweeney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Miss Anne-Marie Welsh Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5d. 2 years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Aortic Insufficiency 2° atherosclerosis</u>										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Aortic Insufficiency 2° atherosclerosis</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19 <u>84</u> , to <u>Dec 4</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec 2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>George Richard</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Richard MD			22e. ADDRESS 101 Tunbridge Road Baltimore, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/8/84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland					25a. DATE REC'D. BY REGISTRAR DEC 7 1984					
					25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked as injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



December 1, 1904

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 8 6
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		CHRIS F. WERNER		DECEMBER 6, 1984		4:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
MALE		WHITE		OCT. 17, 1906		78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				BALTIMORE COUNTY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
21236		4108 KAHLSTON ROAD		LINEMAN		UTILITY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS / ZIP CODE	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21236	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN A. WERNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA C. LAUTENSLAGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES		WW II		216-05-1106		RUTH A. VERMILLION 8215 LOCH RAVEN BLVD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>well-differentiated diffuse hist.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dr'd 4/83</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <u>APRIL 19 83</u> to <u>DEC 19 84</u> , that (I) (we) lost saw the deceased alive on <u>11/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Carla S. Alexander, MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/7/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLA S. ALEXANDER, M.D.				22e. ADDRESS LOCH RAVEN VAMC			
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		DEC. 7, '84		GREEN MOUNT CEMETERY		BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.				DEC 7 1984		<u>William E. Johnson</u>	

BP

Item 11 per phone 12/20/84 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 8 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Also Known as Annie M. Wheeler May R. Wheeler		2a. DATE OF DEATH MONTH DAY YEAR 12/14/84		2b. HOUR 5:00P M	
3. SEX female	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR 5 3 94		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nova Scotia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Relay	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) home - 1530 S. Rolling Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Relay	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Levi Rice		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tena Tupper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 800 00 7226		17. INFORMANT ADDRESS Arthur L. Wheeler 711 Woodland Dr. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 18, 1984 , to 12/14 , 19 84 , that (I) (we) last saw the deceased alive on 12/13 , 19 84 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James H. May		DEGREE MD		22c. DATE SIGNED 12/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/18/84	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME ADDRESS Kaufman Funeral Home, 5695 Main St., Elkridge, Md.			25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

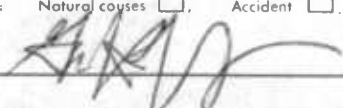
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 2 5 8 8

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST THOMAS		MIDDLE		LAST White		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12/21/ 19 84		7b. HOUR M 8:23 A M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 3, 1904		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12/21/ 19 84		24 HOUR A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? /D/A/ U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11601 Harford Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Inspector		12b. KIND OF BUSINESS OR INDUSTRY G.L. Martin C			
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Glen Arm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11601 Harford Road 21057			
14. FATHER'S NAME FIRST MIDDLE LAST John W. White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellis Siddens									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 486-16-2681		17. INFORMANT ADDRESS James M. Carter, Same As #13e 21057					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound to Mouth</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12/ ? 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) self inflicted wound							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11601 Harford Rd. Balto. Co., Md.							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 12/21/84			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Essex, Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE Jana Wadson-Pandell					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

20 COLON TIBET

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

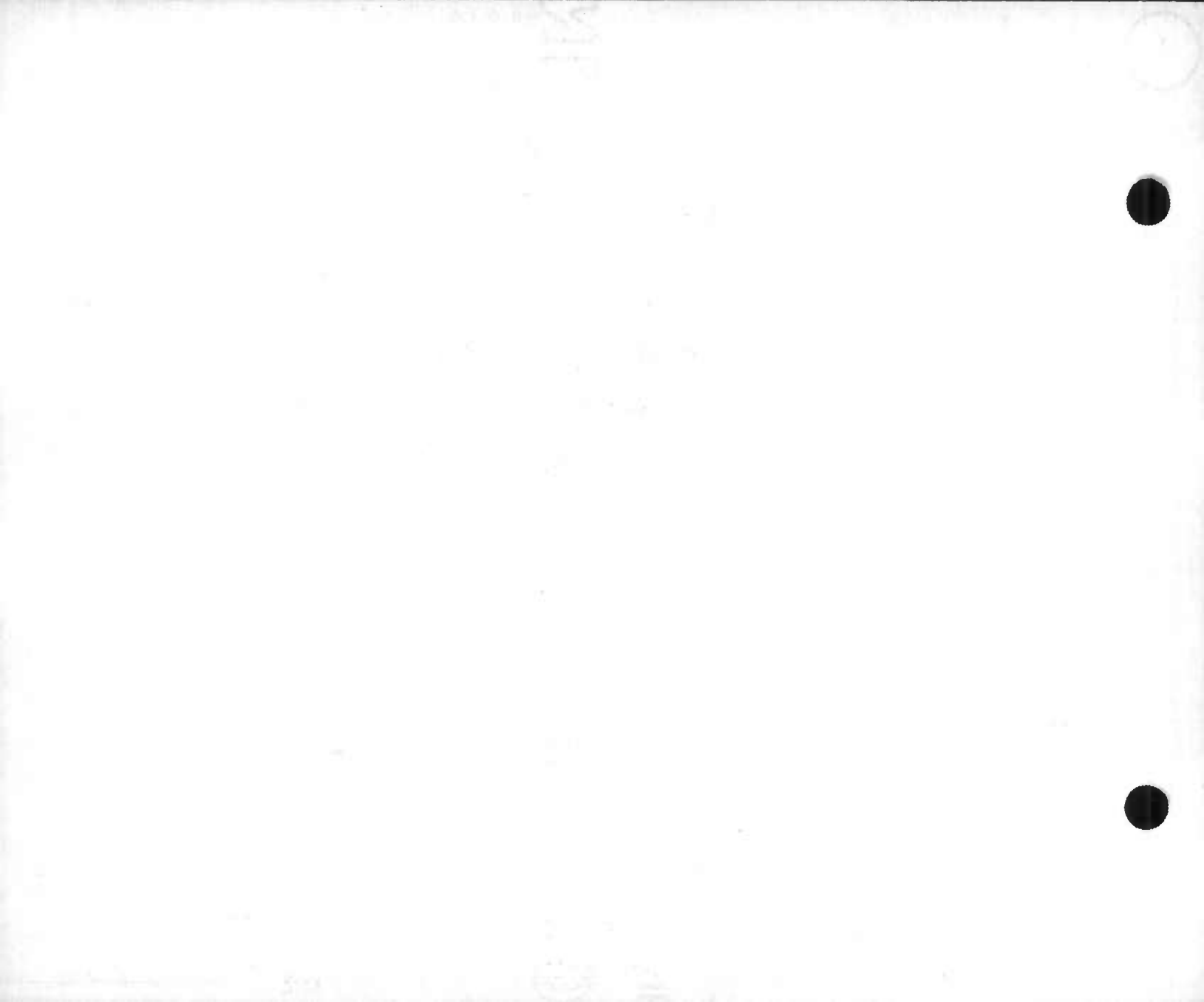
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 8 9 REG. NO.			
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) Warren C. White				2a DATE OF DEATH MONTH 12 DAY 23 YEAR 84				2b HOUR 3:07 A.M.			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH 9 DAY 20 YEAR 20		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10 CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SGHC				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a CITY OR TOWN Edgewood		13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS 2505 Burwood Ct. 21040					
14 FATHER'S NAME FIRST Snowden MIDDLE LAST White		15 MOTHER'S MAIDEN NAME FIRST Flora MIDDLE LAST Long											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NONE		16b SOCIAL SECURITY NO. 234-26-7490		17 INFORMANT SGHC Records				ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Oropharynx, metastatic DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of the Tongue, Primary										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Jan 1/83			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Senile Dementia (b) Seizure Disorder													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 4-27-84 19__ to 12-23-84 19__, that (I) (we) last saw the deceased alive on 12-22-84 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE Dr. Perez				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 12-23-84					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Allan Perez, M.D.				22e ADDRESS 1009 Frederick Rd. Catonsville 21220									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-26-84		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cem		23d. LOCATION CITY OR TOWN Sykesville COUNTY STATE Md.							
24 FUNERAL DIRECTOR NAME MacNabb Funeral Home ADDRESS Catonsville Md				25a DATE REC'D. BY REGISTRAR DEC 27 1984		25b REGISTRAR'S SIGNATURE P. Davidson							

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be buried with the deceased. Page 6 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 32390	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES H. WHITING						2a. DATE OF DEATH MONTH DAY YEAR 12 03 '84			2b. HOUR 7:00 AM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 5 12		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
11. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1413 Gorsuch Ave. 21218			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Whiting				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-09-7653		17. INFORMANT ADDRESS Azeal Whiting 1413 Gorsuch Ave.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE										MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.										YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) MULTIPLE MYELOMA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/ 19 84 , to 12/3 19 84 that (I) (we) last saw the deceased alive on 12/3 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles A. Haile MD</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Dec 4, 84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES HAILE, M.D.						22e. ADDRESS GBMC - 6701 N. CHARLES STREET 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/8/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR DEC 5 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

APR 10 1903

RECEIVED



(A)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

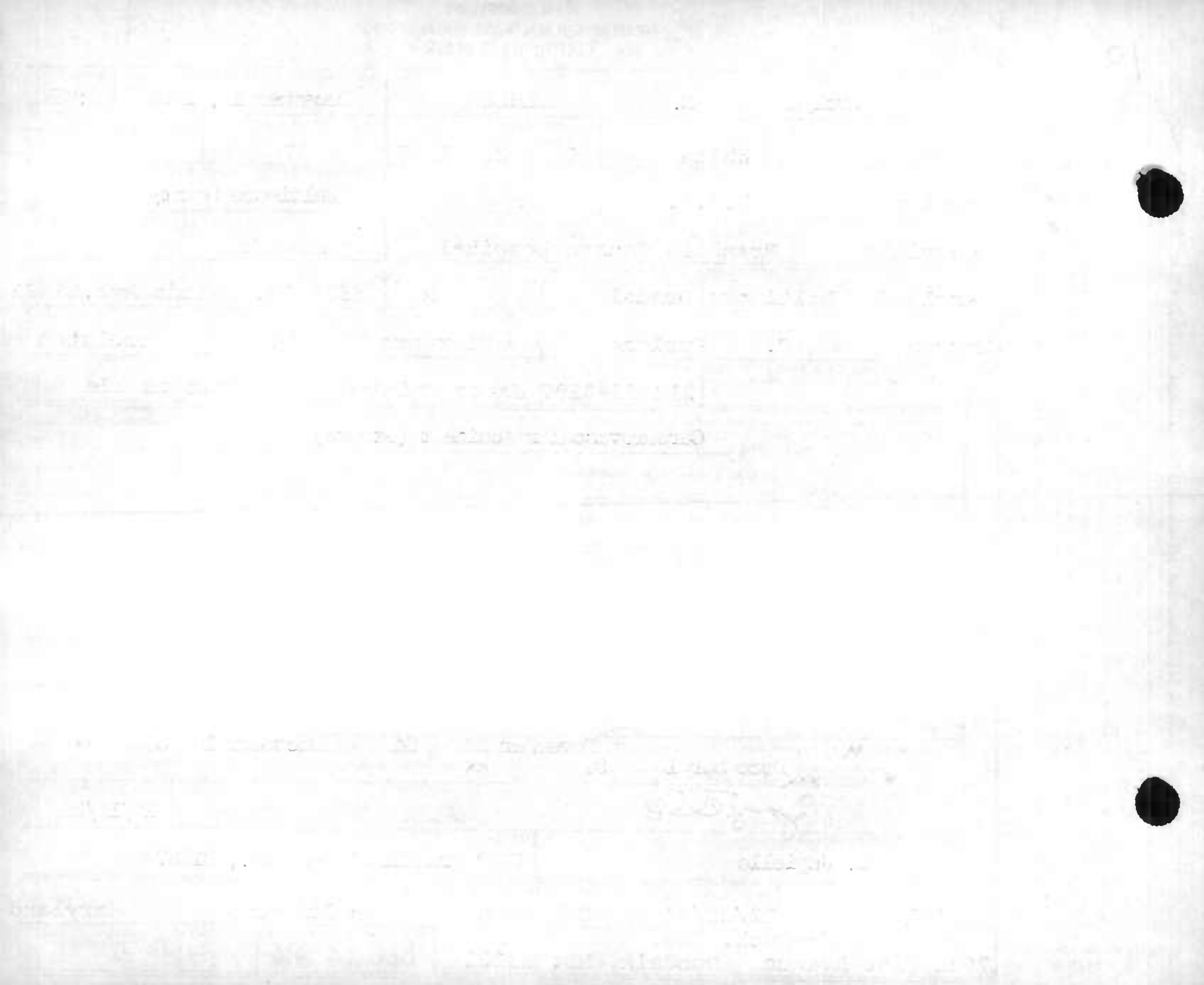
3 2 3 9 1
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
Evelyn E. WHITLOW		December 19, 1984		6:25P _M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	MONTH DAY YEAR 6 25 1907	77 YRS	Baltimore County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rossville	Franklin Square Hospital		Housewife		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	6556 St. Helena Ave. 21222	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Warren G. Furlong	FIRST MIDDLE LAST Florence V. Eccleston				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
No	212-36-8297	James Whitlow	Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident (stroke) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from November 29, 1984, to December 19, 1984, that (we) lost saw the deceased alive on December 19, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
				12/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
B. Jagiello	9000 Franklin Square Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	12/22/84	Oak Lawn	Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 24 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 9 2

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret S. Wilkes			2a. DATE OF DEATH MONTH DAY YEAR 12 19 84			2b. HOUR 2:40 PM			
3. SEX FEMALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 04 07 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST Joseph's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md			13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. DANIELS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES MOORE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 800-07-1983		17. INFORMANT ADDRESS FAMILY RECORDS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ABRUPT</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 5 mins</u> <u>~ 8 hrs.</u> <u>> 10 yrs.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19/84</u> 19 <u>84</u> to <u>12/19/84</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12/19/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John J. Messina M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/19/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John J. Messina M.D.</u>						22e. ADDRESS <u>7401 Osler Dr. Towson, Md. 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>DEC 22, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ROSBAY BALTO MARYLAND</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>EVANS CHAPLOF MEMORIES HARFORD ROAD</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 24 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 3 9 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ADDIE WILLIAMS				2a. DATE OF DEATH MONTH DAY YEAR 12/27/84			
3. SEX F				2b. HOUR 10 AM			
4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8/27/94		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input 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7

[Faint, illegible handwriting and markings throughout the page, including a large 'X' and a circular stamp at the bottom center.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon-pen. Pages 1 and 2 should be filed with the 212 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 9 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Mildred Williams</i>			7a. DATE OF DEATH MONTH DAY YEAR <i>12/19/84</i>			7b. HOUR <i>6:45 PM</i>					
3. SEX <i>FEMALE</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 29 21</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YES		8. IF UNDER 1 YEAR MONTHS DAYS		9. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>STELLA MARIS HOSPICE</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14. STATE <i>Md.</i> 15. COUNTY				13b. CITY OR TOWN <i>Balto.</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS, / ZIP CODE <i>1711 Chilton St. 1st. Fl. 21218</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Williams</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rosa</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Naomi Brown 1711 Chilton St. 1st. Fl.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>December 9</i> 19 <i>84</i> , to <i>December 19</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>December 19</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>DR Foulkner MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>12/18/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PAV KNEC</i>				22e. ADDRESS <i>STELLA MARIS HOSPICE</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12-22-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Cem.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H 1101 E. North Ave.</i>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>DEC 20 1984</i> <i>John Davidson-Randall</i>					

2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 3 9 5
REG. NO.FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RICHARD B. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 10, 1984		2b. HOUR 11 ⁰⁰ AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 22, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Novitt Bancroft Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie McCann		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-32-6589		17. INFORMANT ADDRESS Sandra J. Williams - Same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Flaccid Paralysis DUE TO, OR AS A CONSEQUENCE OF (b) CON - DULMONACE; RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) Severe Syphilis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Liver Hematoma					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) STREET	21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sam Brating				22c. DATE SIGNED 12/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMI BRATING				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-13-84	23c. NAME OF CEMETERY OR CREMATORY Green Mount	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	25a. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	25c. DATE DEC 17 1984

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be looked at once.

and William

Tolson Saint Joseph Hospital

Attn: Mr. E. J. [unclear]
C/O [unclear]
[unclear] [unclear]
[unclear]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 3 9 6
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mabel Ruth Williamson			2a. DATE OF DEATH MONTH 12 DAY 17 YEAR 84		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 15 YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3485 McShane Way 21222		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST George MIDDLE LAST Luhn		15. MOTHER'S MAIDEN NAME FIRST Amelia MIDDLE LAST Reid		16. ADDRESS 7412 Weymouth Way Balto. MD 21222	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-26-1899		17. INFORMANT Lilly May Toft	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **ARTERIO SCLEROTIC HEART DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION nil		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED nil		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR nil		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) nil	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) nil		21f. LOCATION STREET nil CITY OR TOWN nil COUNTY nil STATE nil	
22a. I certify that (I) (this hospital) attended the deceased from JAN 1982 to 12-17-1984 , that (I) (we) last saw the deceased alive on 12-5-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Signy Lonke				22c. DATE SIGNED 12/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 2900 SURREY ROAD				22e. ADDRESS DUNDALK 21222	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/20/84	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	23d. LOCATION CITY OR TOWN Dorsey COUNTY Howard STATE Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk, Inc. ADDRESS 7922 Wise Ave. Dundalk, MD 21222		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

BP

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RECEIVED
JAN 10 1911

1121

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 3 9 7 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST Frank		MIDDLE J.		LAST Wills, Jr.		2a. DATE OF DEATH MONTH DAY YEAR December 5, 1984			2b. HOUR 10:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1305 Midvale Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman			12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1305 Midvale Avenue-21228						
14. FATHER'S NAME FIRST MIDDLE LAST Frank J. Wills, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Reynolds								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 212-09-7142		17. INFORMANT Catonsville, Md. 21228 Mrs. Louise G. Wills-1303 Midvale Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension - Bone Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prostate Cancer</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>1 mo - 2 yrs</u> <u>4 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> , 19 <u>84</u> , to <u>12/5</u> , 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>12/4</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Wm C Waterfield</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/6/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wm C. Waterfield MD</u>				22e. ADDRESS <u>St Agnes Hospital</u> <u>900 Catm Ave Balto Md 21229</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/10/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>				
24. FUNERAL DIRECTOR NAME <u>John A. Moran, Inc. Funeral Home</u>				DATE REC'D. BY REGISTRAR <u>DEC 7 1984</u>				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		3 2 3 9 8				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY MIDDLE T. LAST Wills		2a. DATE OF DEATH MONTH DAY YEAR		12-16-84		2b. HOUR 12 30 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 21 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto., County MD			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 607 Chapel Gate Lane 21229	
14. FATHER'S NAME FIRST James MIDDLE LAST Edelen		15. MOTHER'S MAIDEN NAME FIRST Elizabeth M. MIDDLE LAST Farrell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 216-07-3681		17. INFORMANT ADDRESS 6907 Stratford Dr. D Mrs. Anna R. Swann Sykesville Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19 <u>80</u> to <u>12/16</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eddie Nakhuda		22e. ADDRESS STELLA MARIS - Dulaney Valley Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-19-84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem		23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md.			
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville Md		25a. DATE REC'D. BY REGISTRAR DEC 21 1984		25b. REGISTRAR'S SIGNATURE			



3 2 3 9 9
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A	
STELLA KNA		I. WILSON		DECEMBER 19, 1984		1:00 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		DEC. 24, 1905		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
RANDALLSTOWN		5430 OLD COURT RD., APT. 301 (21133)		HOUSEWIFE		AT HOME	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		BALTIMORE		RANDALLSTOWN		21133	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE			
WILLIAM WEINSTEIN		ROSE TABACHNICK		5430 OLD COURT RD., APT. 301			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		240-16-5539		JAMES W. WILSON 5430 OLD COURT RD., APT. 301			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CVA							
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
				OCT 19 84			
22a. I certify that (I) (this hospital) attended the deceased from AUG 19 84 to OCT 19 84, that (I) (we) last saw the deceased alive on OCT 19 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul S. Sapir MD				DEGREE		22c. DATE SIGNED 12/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SAPIR MD				22e. ADDRESS BALT MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-20-84		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE	
						BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 4 0 0	
1- FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST RUSSELL E WILT, SR.						12-17-1984				1:50 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-23-1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. River Circle Way 21227						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker		12b. KIND OF BUSINESS OR INDUSTRY Steel - Steel	
13a. STATE Ind.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1166 W. Homberg St. 21230			
14. FATHER'S NAME FIRST MIDDLE LAST Ashford T. Wilt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May E. FANIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-10-0807A		17. INFORMANT Ashford T Wilt 1134 W. Homberg St. 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of esophagus = metastasis DUE TO, OR AS A CONSEQUENCE OF (b) and Terminal Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/2 1984 to 12/16 1984, that (I) (we) last saw the deceased alive on 12/16 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Kuang-yen Huang MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG M.D.				22e. ADDRESS BON Secours Hospital							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 12-19-1984		23c. NAME OF CEMETERY OR CREMATORY Meadowdale		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Howard Co. Ind.			
24. FUNERAL DIRECTOR J. Comer 1 So. So. 901 Hollins Ave				25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rodgers					

BP _____

[Faint, illegible handwriting throughout the page]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 0 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>KAROLINA WISNIEWSKI</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>DECEMBER 10 1984</i>		2b. HOUR <i>7 AM</i>
3. SEX <i>FEMALE</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 8 97</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE County, MD.</i>		
10. CITY OR TOWN OF DEATH <i>Towson</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>STELLA MARIS HOSPICE</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. CITY OR TOWN <i>Baltimore</i>	13c. CITY OR TOWN <i>Towson</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Andrew Tomala</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Antonia Sova</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-38-6661</i>	17. INFORMANT ADDRESS <i>Frances Adolph Same</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>SMALL BOWEL obstruction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Colon Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>November 20 19 84</i> to <i>December 10 19 84</i> , that (I) (we) last saw the deceased alive on <i>December 10 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>K. Faulkner M.D.</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kendall Faulkner, M.D.</i>				22e. ADDRESS <i>Stella Maris Hospice Towson, Md. 21204</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 13, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Dindale, Balto. Co., Md.</i>		23e. DATE RECD. BY REGISTRAR <i>DEC 14 1984</i>			
24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld Home, Inc.</i>		ADDRESS <i>6500 York Rd. Balto., Md. 21212</i>		25a. DATE RECD. BY REGISTRAR <i>DEC 14 1984</i>	
25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 0 2
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rev. Maurice Wolfe			2a. DATE OF DEATH MONTH DAY YEAR 12 12 84			2b. HOUR 2 A M				
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 1 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA - belad		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD.				
10. CITY OR TOWN OF DEATH Towson Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice RC Priest				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Religious		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE md			13b. COUNTY HARFORD		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1450 Abingdon Rd 21009	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel M. Wolfe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Hanlon			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 800-00-9153			17. INFORMANT Fr. Lafferty, St. Ignatius Church				17. ADDRESS Hickory, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 28, 19 84, to Dec 12, 19 84, that (I) (we) lost saw the deceased alive on 12-11-84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Nakhuda		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Nakhuda		22e. ADDRESS Dulaney Valley Rd 21204 Stella Maris Hospice					

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12-15-84		23c. NAME OF CEMETERY OR CREMATORY St. Frances de Sales Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS St. Imunek Funeral Home, Inc. 9705 Belair Road, Balto., Md. 21236				25a. DATE REC'D. BY REGISTRAR DEC 14 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be placed in 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 0 3 REG. NO.					
1. FOR STATE REGISTRAR										7a. DATE OF DEATH				7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH Goodman WOODARD										12 22 84				10:45pm	
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 9 04 02			6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH BALTO CO MD.						
10 CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCES SCOTT KEY HOSPITAL							12a. OCCUPATION Asst. Superintendent			12b. KIND OF BUSINESS OR INDUSTRY Blast Furnace Steel Mfg.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Dundalk			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2904 Dunmore Road 21222			
14 FATHER'S NAME FIRST MIDDLE LAST Claud Woodard						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lane Dalton									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 218-18-1259		17. BIRTHPLACE AND ADDRESS Brian R. Woodard 3602 Campbell Rd. Va. 23602 Claud Woodard 131 Maybin Cr.							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardiovascular disease 10 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 31</u> 19 <u>80</u> to <u>Dec. 22</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec. 16</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>M. Rainess, M.D.</u> DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-23-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRIS RAINESS, M.D.										22e. ADDRESS 1105 OLD EASTERN AVE BALTO, MD 21221					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Dundalk, MD 21222										25a. DATE REC'D. BY REGISTRAR DEC 28 1984				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 4 0 4	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			7b. HOUR		
Ora Dell Young			December 17, 1984			8:15 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		09 - 29 - 86		98		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			Meridian Nursing Cnt./Catonsville			Housewife			Home		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			--		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5267 Cordelia Rd. 21215		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
James Polk Lowe					Martha D. Kerby						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					N/A		212-74-6166 Mr. William E. Young Balto., Md. 21228				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory - Cardiac Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD, probable MI</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastritis, Hiatal Hernia</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>55</u> , 19 <u>Dec. 17</u> , 19 <u>84</u> , that (I) (<input checked="" type="checkbox"/>) lost saw the deceased alive on <u>Dec. 17</u> , 19 <u>84</u> , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/>) (did) (<input checked="" type="checkbox"/>) (did not) view the body after death.											
22b. SIGNATURE <i>John H. Shaw</i>					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Shaw, M.D.					22e. ADDRESS 5800 Edmondson Ave. Balto., Md. 21228						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			12/20/84		Lowe Cemetery			Pine Grove, Wetzel Co. W. Va.			
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home					ADDRESS Catonsville, Md.		25. DATE REC'D. BY REGISTRAR DEC 21 1984				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 0 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FRANCIS G. ZELLERS				2a. DATE OF DEATH MONTH DAY YEAR DEC. 22, 1985			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10/27/21		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 128 LANGLEY RD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST ZELLERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 166 12 7230	
17. INFORMANT LOLA ZELLERS		ADDRESS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS OF LIVER DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOL ABUSE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ()							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-21 , 19 84 , to 12-22 , 19 84 , that (I) (we) last saw the deceased alive on 12-21 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE BA YIN OUNG DEGREE BA YIN OUNG, M.D., P.A.				22c. DATE SIGNED 8022 BELAIR RD.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OUNG				22e. ADDRESS BALTO., MD: 21236			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/24/84		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILLS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MACE				25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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Handwritten notes and scribbles, mostly illegible due to bleed-through from the reverse side of the page.

SA YINGUINO MED. P.A.
1001 N. 1st St.
New York

Handwritten notes at the bottom of the page, including the word "Faint" and other illegible text.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 4 0 6
REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MARY S. LAST ZEMAN		DECEMBER 2, 1984 4:15 AM	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
		APRIL 30, 1905		79 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	USA			BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY OF DEATH)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
TOWSON	SAINT JOSEPH HOSPITAL		HOMEMAKER		HOME
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE	
Md	BALTO.	BALTO.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1716 PIN OAK Rd 21234	
14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
ANTON HENRY SCHULT	sophia Stendefelt				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT ADDRESS			
NO	217-03-27500	ANNA S. KLUMPP 2400 WINDSOR Rd.		21234	
10 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Congestive					
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 11-3 1984, to 12-2 1984, that (I) (we) last saw the deceased alive on 12-2 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
A.H. GILADI				12-2-84	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
A.H. GILADI		7600 OSLER Dr. TOWSON		21204	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	DEC 5, 1984	BOHEMIAN NATL	BALTIMORE MD.		
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
HARTLEY Miller 7527 Harford Rd.		DEC 4 1984		Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 0 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Mrs. Dorothy Lorraine Zimmerman				2a. DATE OF DEATH MONTH DAY YF# December 26 1984				2b. HOUR 9:16A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 11 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Hebbsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7514 Windsor Mill Road 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Roland Mattison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Helmker Mattison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-50-5905		17. DECEASED'S ADDRESS Mr. William N. Zimmerman Sr. 7514 Windsor Mill Road Baltimore Maryland 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF: (c) 2 vessel coronary Artery Dis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1 hour > 4 years > 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: hypertension, Diabetes Mellitus chronic obstructive lung dis.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 1980 to Dec 26 1984 , that (I) (we) last saw the deceased alive on Dec 26 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. C. Selig M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edith C. Galvez M.D.				22e. ADDRESS 5400 Old Coast Road Randallstown MD 21133					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-84		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133						25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Gubia, David	

BP _____

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mr. Russell M. Zimmerman		2a. DATE OF DEATH MONTH DAY YEAR December 21 1984		2b. HOUR 8 12 A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 6 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Baltimore Co.
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Franklin Lee Zimmerman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriott Emma Meekins Zimmerman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-4434	17. INDEMNITY ADDRESS Mrs. Lois Green 129 Westminster Pike Reisterstown Maryland 21136		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE; ACUTE RENAL FAILURE				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12-13 19 84 to 12-21 19 84 , that (I) (we) last saw the deceased alive on 12-21 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE [Signature]	DEGREE		22c. DATE SIGNED 12-21-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONNAN M.D.		22e. ADDRESS 13064 - RANDALLSTOWN Rd. 21133		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-24-84	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133		25a. DATE REC'D. BY REGISTRAR DEC 27 1984	25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

513-10-4434

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		2c. MIN.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Ethel GREENE Zumbro				12 1 84		5 30 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		98 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
36 Balto. Md.		U.S.				Balto. Co.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
90 Cockeysville		Md. Masonic Home		Homemaker					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE			
36 Md		Balto		Balto.		Box 96 Garrison Forest Rd. 21117			
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
36 Samuel George Greene		Elizabeth Rapp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
1 No		220-20-0614		Mrs. Ethel Koors		Reisterstown, Md. 21136			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac Arrest									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Unknown									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Paul Rivas				12-09-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Paul Rivas		Maryland Masonic Home							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		12-11-84		Druid Ridge		Pikesville Baltimore Maryland			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld Home		6500 York Road 21212		DEC 12 1984		Davidson-Randall			

BP

(A)

10/10/10

(10/10/10)

(10/10/10)